| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| CAMELLIA GARDENS CENTER FOR NURSING AND REHAB | 280 SOUTH BECKFORD DRIVE HENDERSON, NC 27536 |

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| E 000 | Initial Comments<br><br>An unannounced recertification and complaint investigation survey was conducted on 8/26/2024 through 8/29/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Evebnt ID# 0PUO11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A recertification and complaint investigation survey was conducted from 8/26/2024 through 8/29/2024. Event ID# 0PUO11.<br><br>The following intakes were investigated NC00221379, NC00210496, NC00216533, NC00213573, NC00214500, NC00209713, NC00217566, NC00220793, NC00212801, and NC00210606.<br><br>23 of the 23 complaint allegations did not result in a deficiency. | F 000 | | |
| F 565 SS=E | Resident/Family Group and Response<br>CFR(s): 483.10(f)(5)(i)-(iv)(6)(7)<br><br>§483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility.<br>(i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.<br>(ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.<br>(iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. | F 565 | | 9/25/24 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/19/2024

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| F 565 | Continued From page 1<br>(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.<br>(A) The facility must be able to demonstrate their response and rationale for such response.<br>(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.<br><br>§483.10(f)(6) The resident has a right to participate in family groups.<br><br>§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.<br>This REQUIREMENT is not met as evidenced by:<br>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.<br><br>Findings included:<br><br>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.<br><br>The Resident Council minutes for the period October 2023 through July 2024 were reviewed and revealed the following: | F 565 | On 9/19/2024 a review of the Resident Council meetings for October 2023, January 2024, and June 2024 were reviewed by the Administrator. The Resident Council concerns from the three months were written onto a grievance form. The concerns were then logged in the grievance logbook and assigned to the appropriate department designee to be investigated. The Administrator requested the investigation be returned to her in 72 hours.<br>On 9/20/2024 the Administrator attended a Resident Council meeting to discuss resident council concerns and the communication/follow up process.<br>On 9/19/2024 the Regional Nurse Consultant provided education to the | |

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| F 565 | Continued From page 2<br><br>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.<br><br>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.<br><br>Resident Council minutes dated 2/29/24 revealed no response from the facility for the previous month concerns.<br><br>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.<br><br>Resident Council minutes dated 7/25/24 included no documentation of the facility's response to the concerns voiced during the previous meeting.<br><br>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.<br><br>During an interview with the Administrator on 8/28/24 at 11:50 AM, she revealed that all grievances, including Resident Council | F 565 | Administrator. The education read; the facilities designated staff member, that was approved by the resident or family group (Resident Council), is responsible for conveying any written requests that result from the group meeting. The facility must act promptly upon the grievances and recommendations of the groups concerning issues of resident care and life in the facility. The facility must then be able to demonstrate the response and rationale for the response. The Administrator provided education to the Activities Director and Social Worker, on 9/19/2024, that included the above education. The Activities Director is to communicate the resident council concerns to the Administrator and Social Worker in written form. The Social Worker will log the concern, and the Administrator will assign the concern to the appropriate department designee to complete an investigation. The investigation is to be returned to the Administrator or designee within 72 hours or request additional time to investigate, if needed. A response to the investigation will then be provided to the Resident Council with a rationale for the response.<br>The Administrator or designee will monitor the Resident Council meeting minutes monthly x 3 months to ensure any concerns were written onto a grievance form, documented in the grievance log, investigated, and a rationale communicated to the Resident Council. This will start with the September 2024 Resident Council meeting.<br>The Administrator will review the data for | |

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| F 565 | Continued From page 3<br>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.<br><br>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.<br><br>During a follow-up interview with the SW on 8/28/24 at 12:16 PM, she revealed that if a | F 565 | patterns or trends and will take this information to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 3 months. The QAPI committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed. | |

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| F 565 | Continued From page 4<br>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.<br><br>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. | F 565 | | |
| F 576 SS=C | Right to Forms of Communication w/ Privacy<br>CFR(s): 483.10(g)(6)-(9)<br><br>§483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense.<br><br>§483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with | F 576 | | 9/25/24 |

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| F 576 | Continued From page 5<br>individuals and entities within and external to the facility, including reasonable access to:<br>(i) A telephone, including TTY and TDD services;<br>(ii) The internet, to the extent available to the facility; and<br>(iii) Stationery, postage, writing implements and the ability to send mail.<br><br>§483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to:<br>(i) Privacy of such communications consistent with this section; and<br>(ii) Access to stationery, postage, and writing implements at the resident's own expense.<br><br>§483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research.<br>(i) If the access is available to the facility<br>(ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident.<br>(iii) Such use must comply with State and Federal law.<br>This REQUIREMENT is not met as evidenced by:<br>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.<br><br>The findings included:<br><br>An interview with members of the Resident Council on 8/27/24 at 1:33 PM revealed the | F 576 | On 09/11/2024 the administrator completed an audit on mail delivery to the residents. Any mail that had not been delivered to residents was delivered at that time.<br>On 9/19/2024 the Nursing Home Administrator educated receptionist and facility management team who complete Manager on Duty tasks on Saturdays | |

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| F 576 | Continued From page 6<br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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 | F 576 | regarding delivering resident mail each day the postal service delivers, including weekends. When mail is delivered on the weekends, the receptionist will notify the Manager on Duty who will deliver the mail to the residents. Any newly hired receptionists and/or facility management hired after 9/19/2024 will be educated during orientation.<br>The Administrator or designee will complete an audit on weekend mail delivery 1x/week x8 weeks to ensure residents' mail is being delivered on weekends.<br>The Administrator will forward the results of the weekend mail delivery audit to the QAPI Committee monthly x2months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring. | |

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| F 576 | Continued From page 7<br>(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.<br><br>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.<br><br>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. | F 576 | | |
| F 578 SS=E | Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir<br>CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)<br><br>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.<br><br>§483.10(g)(12) The facility must comply with the | F 578 | | 9/25/24 |

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| F 578 | Continued From page 8<br>requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.<br>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.<br>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.<br>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.<br>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.<br>Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.<br>This REQUIREMENT is not met as evidenced by:<br>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).<br><br>The findings include:<br><br>a. Review of Resident #1's medical record | F 578 | Residents #1, 5, 28, 29, and 47 continue to reside in the facility and remain in stable condition. Residents #5 and 28 are unable to formulate Advance Directive due to cognitive impairment. Social Service spoke with residents # 1, 29, and 49 regarding formulation of an Advance Directive. Resident #1 chose to not formulate an Advance Directive at this time; Resident #29 chose not to formulate | |

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| F 578 | Continued From page 9<br>revealed the resident was readmitted to the facility on 11/19/15, 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.<br><br>b. Review of Resident #5's medical record revealed the resident was admitted to the facility on 3/18/24, 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.<br>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.<br><br>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.<br><br>c. Review of Resident #28's medical record revealed the resident was readmitted to the facility on 3/21/24, 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 | F 578 | an Advance Directive at this time; and Resident #47 chose to not formulate an Advance Directive at this time. Social service provided Residents #1, 29, and 49 Advance Directive information, and documented in the residents' health record.<br>On 9/19/2024 the Regional Nurse Consultant completed education with Social Service, Admissions Coordinator, Director of Nursing, and Medical Records regarding the resident's right to formulate an Advance Directive to ensure Social Worker reviewed Advance Directive information regarding the right to formulate, or decline to establish, an advance directive with the resident and documentation was provided in the medical record.<br>On 9/19/24 the Director of Nursing and Regional Nurse Consultant completed an Advance Directive audited medical records of current residents who are alert and oriented to ensure documentation was present regarding the discussion of Resident Right to formulate, or decline to establish, an Advance Directive. Areas of concern were addressed by Social Service.<br>The Nursing Home Administrator will review all admissions during Interdisciplinary Team Meeting (IDT) 5 times a week for 4 weeks, then monthly for 2 months. This audit is to ensure that the Social Worker reviewed advance directive information regarding the right to formulate, or decline to establish, an advance directive with the resident and documentation was provided in the | |

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| F 578 | Continued From page 10<br>and/or an opportunity to formulate an advance directive was offered.<br><br>d. Review of Resident #29's medical record revealed the resident was readmitted to the facility on 3/17/21, 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.<br><br>e. Review of Resident #47's medical record revealed the resident was admitted to the facility on 4/12/23 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.<br><br>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.<br><br>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. | F 578 | medical record.<br>The Administrator will forward the results of the Advance Directive audit to the QAPI Committee monthly for 3 months. The QAPI Committee review the Advance Directive audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring. | |

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| F 580 | Continued From page 11 | F 580 | | |
| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and | F 580 | | 9/25/24 |

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| F 580 | Continued From page 12<br>phone number of the resident representative(s).<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br>This REQUIREMENT is not met as evidenced by:<br>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).<br><br>The findings included:<br><br>1. Resident #24 was admitted to the facility on 4/19/24 with diagnoses which included malignant neoplasm of female breast and vascular dementia.<br><br>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.<br><br>Review of Resident #24's Medication Administration Record (MAR) for the month of August 2024 revealed the letrozole medication | F 580 | Resident #24 and Resident #269 continue to reside at the facility. The Primary care physician/Nurse Practitioner was notified of Resident #24 and Resident #269 having missed medication administration on 8/29/2024.<br>An audit was completed of ordered medications, on 9/19/2024, by the Administrator or designee on new and current residents ensuring the physician was notified when prescribed meds were not administered as ordered for new or long-term care residents. Any medication that was not able to be administered will have a physician notification.<br>The Director of Nursing (DON) was provided education by the Regional Nurse Consultant on 9/19/2024 of the requirements to monitor medication orders for current residents and provide physician notification if a medication was not able to be administered as ordered.<br>The DON will provide education to clinical nursing staff that the physician must be notified when a medication was not able | |

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| F 580 | Continued From page 13<br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>An interview was conducted on 8/27/24 at 1:09 pm with the Medical Director who revealed she | F 580 | to be administered as ordered. Clinical nursing staff that have not received the education by 9/24/2024 will not be able to work until the education is completed. Newly hired nurses will receive the education during orientation by the DON or designee.<br>The DON or designee will monitor medication administration documentation on ten residents to audit missed medication administration. This audit will occur three days a week x 4 weeks, then two days a week x 4 weeks, then weekly x 4 weeks. The DON or designee will ensure physician notification occurred if a medication was not administered as ordered.<br>The DON will review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 3 months. The QAPI committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed. | |

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| F 580 | Continued From page 14 | F 580 | | |

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.

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.

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.

2. Resident #269 was admitted to the facility on 8/23/24 with diagnoses which included osteomyelitis and complications of stump infection.

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.

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.

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| F 580 | Continued From page 15<br>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.<br><br>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.<br><br>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.<br><br>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. | F 580 | | |
| F 610 SS=D | Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: | F 610 | | 9/25/24 |

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| F 610 | Continued From page 16<br>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.<br><br>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>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.<br><br>The findings included:<br><br>Resident #29 was initially admitted to the facility on 5/6/19 and readmitted on 3/17/21 with diagnoses that included stroke and mild cognitive impairment.<br><br>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 | F 610 | Resident #29 continues to reside in the facility and remains stable. Resident has had no complaints/allegations of abuse. Administrator spoke with resident regarding occurrence of 8/29/23 and resident did not remember occurrence.<br>On 9/19/2024 the Regional Nurse Consultant educated the Nursing Home Administrator and Director of Nursing regarding investigations of alleged abuse to include maintaining complete investigations in a secure area which Administrator and Director of Nursing have access.<br>The Regional Nursing Consultant will complete an audit of facility investigations to ensure investigations are completed and maintained in a secure area which the Administrator and Director of Nursing have access. Audit will be completed 1x/week x4 weeks then monthly x2 months.<br>The Administrator will forward the results | |

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| F 610 | Continued From page 17<br>include any evidence that the resident interviews and assessments were completed. The allegation was not substantiated.<br><br>An interview with the Vice 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.<br><br>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.<br><br>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. | F 610 | of the investigation audit to the QAPI Committee monthly x3 months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring. | |
| F 623 SS=E | Notice Requirements Before Transfer/Discharge<br>CFR(s): 483.15(c)(3)-(6)(8)<br><br>§483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a resident, the facility must-<br>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.<br>(ii) Record the reasons for the transfer or discharge in the resident's medical record in | F 623 | | 9/25/24 |

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| F 623 | Continued From page 18 | F 623 | | |

accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which

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| F 623 | Continued From page 19 | F 623 | | |

receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as

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| F 623 | Continued From page 20<br>well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k).<br>This REQUIREMENT is not met as evidenced by:<br>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).<br>The findings included:<br><br>1.Resident #221 was admitted to the facility on 10/15/19.<br><br>The quarterly MDS dated 11/30/23 revealed Resident #221 was severely cognitively impaired.<br><br>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.<br><br>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.<br><br>Interviews attempted with the nurse that was assigned to Resident #221 when she was transferred to the hospital on 1/21/24 were unsuccessful. | F 623 | Residents #119 and 221 no longer reside in the facility.<br>On 9/12/2024 the Administrator completed an audit of residents who were discharged to the hospital in the past 30 days to ensure the resident representative and Ombudsman were notified in writing of the resident's transfer to the hospital and the reason for transfer. Any concerns identified were addressed by Social Service at the time of the audit.<br>On 9/19/2024 the Nursing Home Administrator educated the Social Worker regarding notification of Ombudsman of residents' hospital transfer. Education was also provided the nursing staff regarding providing the resident/resident representative the facility's bed hold policy.<br>The administrator/designee will conduct an audit of Ombudsman and resident representative notification of residents' hospital transfer to ensure Ombudsman and resident representative are notified of residents' transfer to the hospital and reason for transfer. Audit will be completed 5x/week x4 weeks then weekly x 2 months.<br>The Administrator will forward the results of the notification audit to the QAPI Committee monthly for 3 months. The QAPI Committee will review the notification audit to determine trends and/or issues that may need further | |

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| CAMELLIA GARDENS CENTER FOR NURSING AND REHAB | 280 SOUTH BECKFORD DRIVE HENDERSON, NC 27536 |

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| F 623 | Continued From page 21<br>Interviews attempted with the Resident's Responsible Party were unsuccessful.<br><br>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.<br><br>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.<br><br>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.<br><br>An interview was completed on 8/29/24 at 11:00 AM with the facility's Social Worker. The Social | F 623 | interventions put into place and to determine the need for further and/or frequency of monitoring. | |

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| F 623 | Continued From page 22 | F 623 | | |

Worker stated she was unaware it was her responsibility to notify the Ombudsman of a resident's transfer from the facility.

2. Resident #119 was admitted to the facility on 5/21/21.
The quarterly Minimum Data Set (MDS) assessment dated 4/19/24 revealed Resident #119 was severely cognitively impaired.
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.
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.

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.

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.

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

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| F 623 | Continued From page 23<br>from the facility each month.<br><br>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. | F 623 | | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>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).<br><br>The findings included:<br><br>Resident #269 was admitted to the facility on 8/23/24 with diagnoses which included osteomyelitis and complications of stump infection.<br><br>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.<br><br>Resident #269 had a care plan initiated on 8/23/24 for enhanced barrier precautions related | F 658 | Resident #269 continues to reside in the facility and remains in stable condition. Peripherally inserted central catheter remains in the right arm and has no signs of infection and/or infiltration. Orders for maintaining the PICC line were entered prior to survey exit on 8/28/2024.<br>On 9/19/24, the Director of Nursing completed an audit of residents who currently have a intravenous catheters to ensure physician orders are in place for the management and of the intravenous catheter. Any areas of concern identified were corrected by the Director of Nursing at the time of the audit.<br>On 9/19/24, the Director of Nursing initiated education for licensed nursing staff regarding placing a physician's order for the management of intravenous catheters, to include, flushes, assessment of line/insertion site, dressing changes. | 9/25/24 |

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| F 658 | Continued From page 24<br>to the PICC line and wound with an intervention to monitor for redness or drainage around PICC and wound site.<br><br>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.<br><br>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.<br><br>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.<br><br>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 | F 658 | Education will be completed on 9/24/24. Any licensed nursing staff that were not educated by 9/24/24 will be educated prior to beginning their next scheduled shift. Newly hired licensed nursing staff will be educated during orientation by the Director of Nursing or Unit Manager.<br>The Director of Nursing or designee will conduct an audit on intravenous catheters 3 times a week for 4 weeks then 2 times a week for 2 months to ensure a physician order is written for the management of the intravenous catheters.<br>The Director of Nursing will forward the results of the intravenous catheter audit to the QAPI Committee monthly x3 months.<br>The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring. | |

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| F 658 | Continued From page 25 | F 658 | | |

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.

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.

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.

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| F 658 | Continued From page 26<br>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.<br><br>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. | F 658 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>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)<br><br>Findings include:<br><br>Resident #9 was admitted to the facility on | F 689 | Resident #9 continues to reside in the facility and remains in stable condition. Resident continues to be a supervised smoker and wear an apron.<br>On 9/19/24, Nursing Home Administrator completed an audit of all current smokers to ensure those who require smoking safety equipment have the availability of needed equipment and are utilizing | 9/25/24 |

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| F 689 | Continued From page 27<br>3/29/2023.<br><br>The most recent Minimum Data Set (MDS) dated 4/9/2024, revealed Resident #9 had severe cognitive impairment and indicated Resident #9 was a tobacco user.<br><br>A review of the smoking assessment dated 4/10/2024 revealed Resident #9 was a supervised smoker.<br><br>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.<br><br>Resident #9's care plan dated 5/20/2024 revealed he was a supervised smoker and required to wear a smoking apron when smoking.<br><br>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.<br><br>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. | F 689 | required safety equipment.<br>On 9/19/24, Nursing Home Administrator educated nursing staff regarding direct observation of supervised smokers and ensuring required smoking safety equipment is utilized.<br>On 9/19/24, Nursing Home Administrator spoke with Resident Council President regarding residents supplying smoking paraphernalia to other residents who may be a supervised smoker and need required equipment.<br>Nursing Home Administrator or designee will audit smoking times 3 times a week for 4 weeks then 1 time a week for 2 months to ensure supervised smokers who are required to use smoking safety equipment are utilizing their safety equipment while smoking and ensure a staff member is present for supervised smoking.<br>The Nursing Home Administrator will forward the results of the supervised smoker audit to the QAPI Committee monthly x3 months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring. | |

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| F 689 | Continued From page 28<br><br>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.<br><br>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. | F 689 | | |
| F 727 SS=F | RN 8 Hrs/7 days/Wk, Full Time DON<br>CFR(s): 483.35(b)(1)-(3)<br><br>§483.35(b) Registered nurse<br>§483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.<br><br>§483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. | F 727 | | 9/25/24 |

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| F 727 | Continued From page 29<br><br>§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by:<br>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.<br><br>Findings include:<br><br>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.<br><br>Telephone interviews with the prior Director of Nursing (DON) and Scheduler were attempted but calls and messages were not returned.<br><br>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. | F 727 | Staff schedules were adjusted on 9/19/24 by the Scheduler to ensure proper Registered Nurse (RN) coverage.<br>Current residents are affected by this current deficiency.<br>The Regional Nurse Consultant educated the scheduler, the Director of Nursing and Administrator on 9/19/24 on providing a Registered Nurse in the facility for 8 consecutive hours for a day, 7 days a week.<br>The Administrator and/or designee will audit schedule to ensure a Registered Nurse is in the facility for 8 consecutive hours for a day, 7 days a week weekly x 8 weeks.<br>The Administrator will be responsible for bringing the Registered Nurse audit to the Quality Assurance Performance Improvement Committee x 3 consecutive meetings. The Quality Assurance Committee will determine if further auditing will be required. | |

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| F 755 SS=D | Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>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) | F 755 | Resident #269 continues to reside in the facility and remains in stable condition. Resident admitted to facility on 8/23/2024 at 2:02pm, orders were verified with the | 9/25/24 |

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| F 755 | Continued From page 31<br>antibiotic medication was available as ordered for a newly admitted resident for 1 of 2 residents reviewed for intravenous (IV) antibiotic therapy (Resident #269).<br><br>The findings included:<br><br>Resident #269 was admitted to the facility on 8/23/24 with diagnoses which included osteomyelitis and complications of stump infection.<br><br>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.<br><br>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.<br><br>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.<br><br>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 | F 755 | physician, and placed in health record. Resident's Piperacillin was delivered from Pharmacy at 1:10am on 8/24/2024 and resident received first dose when received by the facility. The Nurse Practitioner was notified of Resident #269 missed administration on 8/29/24.<br>Residents residing in the facility have the potential to be impacted. An audit of new admissions orders, for the last 30 days, was conducted, on 9/19/2024 by the Director of Nursing (DON) or designee. The DON or designee will ensure the nursing staff notify the physician, if delivery time of medications by the pharmacy was scheduled after the first dose was ordered. Any medication not able to be administered will have a physician notification.<br>The DON was provided education by the Regional Nurse Consultant on 9/19/2024 of the requirements to monitor new admission orders and provide physician notification of the time the medication will be delivered to the facility, if the delivery time is after the first dose of medication is due. The Director of Nursing (DON) will provide education to clinical nursing staff that the physician must be notified when a new admission□s medication delivery time is scheduled after the first dose of the medication is due. Clinical nursing staff that have not received the education by 9/24/24 will not be able to work until the education is completed. Newly hired nurses will receive the education during orientation by the Director of Nursing or Unit Manager.<br>The DON or designee will monitor | |

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| F 755 | Continued From page 32 | F 755 | | |

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.

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.

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.

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.

A telephone interview was conducted on 8/29/24 8:15 am with the Consultant Pharmacist who

medication order delivery times for 10 residents three days a week for 4 weeks, then two days a week for 4 weeks, then weekly for 4 weeks. The DON or designee will ensure physician notification occurred if the pharmacy delivery was scheduled after the first dose of medication was scheduled.
The Director of Nursing will review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly x 3 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.

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| F 755 | Continued From page 33<br>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.<br><br>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 8/24/24 at 1:10 am.<br><br>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. | F 755 | | |
| F 756 SS=D | Drug Regimen Review, Report Irregular, Act On<br>CFR(s): 483.45(c)(1)(2)(4)(5)<br><br>§483.45(c) Drug Regimen Review.<br>§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>§483.45(c)(2) This review must include a review of the resident's medical chart.<br><br>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, | F 756 | | 9/25/24 |

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| F 756 | Continued From page 34<br>and these reports must be acted upon.<br>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.<br>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.<br>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.<br><br>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.<br>This REQUIREMENT is not met as evidenced by:<br>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).<br><br>The findings included:<br><br>Resident #24 was admitted to the facility on | F 756 | Resident #24's Haldol order was updated on 8/30/2024 to include the indication of use, schizophrenia.<br>Residents receiving Haldol could be impacted by the deficient practice. An audit of the August 2024 Pharmacy drug regimen review was conducted and pharmacy recommendations and physician responses were verified to be entered into the electronic medical record. This was completed, 9/19/2024. | |

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| F 756 | Continued From page 35<br>4/19/24 with diagnoses which included vascular dementia and schizophrenia.<br><br>The care plan initiated on 5/01/24 revealed Resident #24 used psychotropic medication related to diagnosis of schizophrenia.<br><br>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.<br><br>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.<br><br>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.<br><br>The Minimum Data Set (MDS) quarterly assessment dated 7/26/24 revealed Resident #24 had severe cognitive impairment and was coded for use of an antipsychotic medication.<br><br>A telephone interview was conducted on 8/29/24 | F 756 | The Director of Nursing (DON) were educated by the Regional Nurse Consultant on the process for monthly pharmacy drug regimen reviews on 9/19/24. The education included the requirements for a facility to maintain procedures for the monthly drug regimen reviews that include time frames for the different steps in the process. The DON will provide the monthly pharmacy drug regimen reviews to the Physicians upon receipt of the report from the Pharmacist. The DON will ensure all physician recommendations and/or orders are entered into the electronic medical record on the date the order/recommendation is written by the Physician.<br>An Audit of the monthly pharmacy drug regimen reviews will be conducted monthly for 3 months, by the facility Administrator or designee to ensure all physician orders/recommendations are entered into the electronic medical record. The Administrator or designee will review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly x 3 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed. | |

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| F 756 | Continued From page 36<br>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.<br><br>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.<br><br>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. | F 756 | | |
| F 760 SS=E | Residents are Free of Significant Med Errors | F 760 | | 9/25/24 |

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| F 760 | Continued From page 37<br>CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its-<br>§483.45(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>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).<br><br>The findings included:<br><br>1. Resident #24 was admitted to the facility on 4/19/24 with diagnoses which included malignant neoplasm of female breast and vascular dementia.<br><br>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.<br><br>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.<br><br>The Minimum Data Set (MDS) quarterly assessment dated 7/26/24 revealed Resident #24 had severe cognitive impairment and was coded for chemotherapy medication. | F 760 | Residents #24 and 269 continue to reside in the facility and remain in stable condition. Residents' have not had medications missing/not provided.<br>On 9/19/2024 the Director of Nursing initiated education with nurses and certified medication aides regarding ensuring ordered medications are received, verifying medication delivery, and the notification of the pharmacy and physician if medications are not received timely from pharmacy. Education will be completed by 9/23/2024. Any nurses or certified medication aides who were not educated, will be educated prior to beginning their next scheduled shift. Any newly hired nurses and certified medication aides will be educated in orientation.<br>The Director of Nursing will complete an audit of medication orders 5x/week x4 weeks then weekly x2 months to ensure ordered medications are verified on delivery or pharmacy and physician are notified of medications not delivered timely.<br>The Administrator will forward the results of the medication audit to the QAPI Committee monthly for 3 months. The QAPI Committee will review the medication audit to determine trends and/or issues that may need further | |

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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 7/31/24 and was signed as received by Medication Aide #3.

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.

Review of Resident #24's Medication Administration Record (MAR) for the month of August 2024 revealed the letrozole medication administration on the following dates:

8/01/24 noted as administered by Medication Aide (MA) #4.
8/02/24 noted as administered by Nurse #14.
8/03/24 noted as on order by Nurse #12.
8/04/24 noted as on order by Nurse #3.
8/05/24 noted as administered by Nurse #1.
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

interventions put into place and to determine the need for further and/or frequency of monitoring.

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| F 760 | Continued From page 39 | F 760 | | |

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.

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.

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.

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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.

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.

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.

An observation was conducted on 8/27/24 at 12:34 pm with Medication Aide #2 of the

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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.

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.

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.

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.

An interview was conducted on 8/27/24 at 1:09 pm with the Medical Director who revealed she

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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.

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.

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.

An interview was conducted with the Administrator on 8/29/24 at 9:10 am who

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revealed the DON and Unit Manager were responsible to make sure medications were administered as ordered.

2. Resident #269 was admitted to the facility on 8/23/24 with diagnoses which included osteomyelitis and complications of stump infection.

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.

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.

The Medication Administration Record (MAR) for August 2024 revealed the following:

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.

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.

8/24/24 at 10:00 pm the piperacillin

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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.

The MAR from 8/25/24 through 8/28/24 revealed Resident #269's the piperacillin sodium-tazobactam solution was administered as ordered.

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.

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.

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.

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| F 760 | Continued From page 45<br><br>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.<br><br>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.<br><br>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.<br><br>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. | F 760 | | |
| F 883 SS=E | Influenza and Pneumococcal Immunizations<br>CFR(s): 483.80(d)(1)(2)<br><br>§483.80(d) Influenza and pneumococcal | F 883 | | 9/25/24 |

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| F 883 | Continued From page 46<br>immunizations<br>§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and<br>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.<br><br>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; | F 883 | | |

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| F 883 | Continued From page 47<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and<br>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.<br>This REQUIREMENT is not met as evidenced by:<br>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).<br><br>The findings included:<br><br>a. Resident #28 was admitted to the facility on 4/19/21.<br><br>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.<br><br>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 | F 883 | Resident #10, #16, #28 and #29 were provided education on the influenza and pneumococcal vaccine on 9/19/24.<br>House audit was conducted to identify those lacking documentation of education and refusals. This audit began on 9/19/24 and is ongoing. A plan was formulated amongst the DON and Unit Managers to resolve issues identified.<br>Education was provided to the DON and ADON by the Regional Nurse Consultant regarding the requirements for immunization administration, documentation, and education. The education included how to look up the CDC guidelines and recommendations on the Advanced Committee for Immunization Practices (ACIP), where to locate the ACIP recommendations, and how to share the recommendations with providers. Furthermore, education included obtaining consent and documentation in the electronic medical record. Any newly hired SDC's will | |

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| F 883 | Continued From page 48<br>#28 or their Responsible Party (RP) regarding the influenza and pneumococcal vaccines.<br><br>b. Resident #16 was admitted to the facility on 10/21/22.<br><br>Review of the medical record revealed Resident #16 was administered the influenza immunization at the facility on 10/17/23.<br><br>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.<br><br>c. Resident #29 was admitted to the facility on 5/16/19.<br><br>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.<br><br>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.<br><br>d. Resident #10 was admitted to the facility on 12/30/22.<br><br>Review of the medical record revealed Resident #10 was noted to have obtained the influenza vaccine at the facility on 10/17/23. | F 883 | receive the education in orientation.<br>The Director of Nursing or designee will audit five admissions a week for four weeks, then three admissions a week for eight weeks for documentation of influenza and pneumococcal education and consent/refusal of the vaccination.<br>The Administrator or designee will review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly x 3 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed. | |

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| F 883 | Continued From page 49 | F 883 | | |

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.

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.

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.

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.

An attempt to interview the previous DON was unsuccessful.

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| F 883 | Continued From page 50<br>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. | F 883 | | |
| F 887 SS=D | COVID-19 Immunization<br>CFR(s): 483.80(d)(3)(i)-(vii)<br><br>§483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following:<br>(i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized;<br>(ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine;<br>(iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine;<br>(iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any | F 887 | | 9/25/24 |

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| F 887 | Continued From page 51<br>additional doses;<br>(v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision;<br>(vi) The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and<br>(B) Each dose of COVID-19 vaccine administered to the resident; or<br>(C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and<br>(vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following:<br>(A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine;<br>(B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and<br>(C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN).<br>This REQUIREMENT is not met as evidenced by:<br>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).<br><br>The findings included: | F 887 | Resident #16 and #29 were provided education on the COVID-19 vaccine on 9/19/24.<br>House audit was conducted to identify those lacking documentation of education and refusals. This audit began on 9/19/24 and is ongoing. A plan was formulated amongst the DON and Unit Managers to resolve issues identified. | |

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| F 887 | Continued From page 52<br><br>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.<br><br>a. Resident #16 was admitted to the facility on 10/21/22.<br><br>Review of the medical record revealed Resident # 16 was administered the COVID-19 vaccine at the facility on 12/13/23.<br><br>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.<br><br>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.<br><br>b. Resident #29 was admitted to the facility on | F 887 | Education was provided to the DON and ADON by the Regional Nurse Consultant regarding the requirements for immunization administration, documentation, and education. The education included how to look up the CDC guidelines and recommendations on the Advanced Committee for Immunization Practices (ACIP), where to locate the ACIP recommendations, and how to share the recommendations with providers. Furthermore, education included obtaining consent and documentation in the electronic medical record. Any newly hired SDC's will receive the education in orientation.<br>The Director of Nursing or designee will audit five admissions a week for four weeks, then three admissions a week for eight weeks for documentation of COVID-19 education and consent/refusal of the vaccination.<br>The Administrator or designee will review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly x 3 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed. | |

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| F 887 | Continued From page 53 | F 887 | | |

5/06/19.

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.

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.

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.

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.

An attempt to interview the previous DON was unsuccessful.

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.

| 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 _____ | C 08/29/2024 |

| 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** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|