STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032071	A. BUILDING: _____ B. WING _____	07/30/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on July 29-30, 2025.	D 000		
D 306	10A NCAC 13F .0904(d)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (4) Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure water was served at each meal for 52 of 56 assisted living (AL) residents in addition to other beverages. The findings are: Observation of the lunch meal service on 07/29/25 for the AL dining room between 12:00pm and 12:30pm revealed: -There were 56 residents present for the lunch meal service. -Beverages available included milk, tea, lemonade, and water. -The beverages were served by the dietary staff. -Four residents were served water, and all the other residents were served other beverages. -No other residents were served water. Observation of the breakfast meal service on 07/30/25 for the AL dining room between 8:00am	D 306		

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D 306	Continued From page 1	D 306		

and 8:30am revealed:
-There were 42 residents present for the breakfast meal service.
-Beverages available included milk, juice, coffee and water.
-One resident was served water, and all the other residents were served other beverages.
-No other residents were served water.

Interview with a resident on 07/29/25 at 2:00pm revealed:
-Water was not served with every meal.
-The staff would give her water if she asked for it.

Interview with a second resident on 07/29/25 at 2:35pm revealed:
-Water was never on the table when he went to the dining room.
-He would drink water with his meals if it was on the table.
-He has not requested the water from the staff.

Interview with the Dietary Manager (DM) on 07/30/25 at 11:00am revealed:
-She was aware water was supposed to be served to all residents at each meal service.
-The kitchen staff used to serve water to each resident, but most of them would not drink it.
-She would inform her staff to start serving water to each resident again during the breakfast, lunch and dinner meal services.

Interview with the Resident Care Coordinator (RCC) on 07/30/25 at 11:10am revealed:
-She knew water must be served to all residents with each meal.
-She was not aware water was not being served to each resident.
-She would expect the kitchen staff to serve water to all residents during every meal service.

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D 306	Continued From page 2 Interview with the Administrator on 07/30/25 at 11:25am revealed: -He was not aware water had to be served to all residents at every meal service. -He thought you only had to offer water and milk and one additional beverage. -Now that he was aware of the requirement, he would expect residents to be served water during each meal service.	D 306		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents with an order for finger stick blood sugar (FSBS) checks 3 times a day and sliding scale insulin (SSI) orders with meals who was not receiving insulin according to the sliding scale parameters. The findings are: Review of Resident #1's current FL2 dated 01/08/25 revealed: -Diagnoses included paranoid schizophrenia,	D 358		

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glaucoma, mild intellectual disability, chronic kidney disease, and diabetes mellitus Type II.
-She was intermittently disoriented.
-There was an order for FSBS three times daily.
-There was an order to inject insulin subcutaneously (SQ) per sliding scale; blood glucose (BG) 150-200 inject 2 units(U); BG 201-250 = 4units; BG 251-300 = 6U; BG 301-350 = 8U; BG 351-400 = 10U; and BG 401-450 = 12U.

Review of Resident #1's physician orders dated 03/17/25 revealed an order for insulin aspart U-100 unit/mL (3mL) (fast-acting insulin used to control high blood sugar); inject insulin subcutaneously per SSI.

Interview with the Resident Care Coordinator (RCC) on 07/30/25 at 12:10pm revealed:
-The facility had a binder for recording FSBS values as well as documenting FSBS values on the residents' medication administration records (MARs).
-Medications aides (MAs) could document FSBS values directly on the MAR or in the FSBS binder.
-Some MAs documented on the MARs, some MAs documented FSBS values on the pages in the FSBS binder, and some MAs documented FSBS values on both documents.
-MAs documented SSI coverage administered on the back of the MAR or in the FSBS binder.

Review of Resident #1's May 2025 MAR and May 2025 FSBS binder pages revealed:
-There was an entry to check FSBS three times daily, before breakfast (scheduled at 7:30am), before lunch (scheduled at 11:30am, and before dinner scheduled at 4:30pm.
-There was an entry to administer insulin aspart U-100 insulin pen with meals per SSI scale.

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D 358	Continued From page 4 -There was an entry for SSI for blood sugar with sliding scale blood glucose (BG) 150-200 inject 2 units(U); BG 201-250 = 4units; BG 251-300 = 6U; BG 301-350 = 8U; BG 351-400 = 10U; and BG 401-450 = 12U. -FSBS values ranged from 81 to 218. -There were 28 opportunities when SSI should have been administered. -There were 8 opportunities when SSI should have been administered but no amount of SSI was documented on the MAR or FSBS binder pages. -Examples were as follows: -On 05/03/25 at 7:30am, the FSBS was 191 and 2U insulin aspart should have been administered, but no SSI was documented as administered. -On 05/08/25 at 11:30am, the FSBS was 156 and 2U insulin aspart should have been administered, but no SSI was documented as administered. -On 05/08/25 at 4:30pm, the FSBS was 172 and 2U insulin aspart should have been administered, but no SSI was documented as administered. -On 05/12/25 at 4:30pm, the FSBS was 176 and 2U insulin aspart should have been administered, but no SSI was documented as administered. -On 05/27/25 at 4:30pm, the FSBS was 162 and 2U insulin aspart should have been administered, but no SSI was documented as administered. Review of Resident #1's June 2025 MAR and June 2025 FSBS binder pages revealed: -There was an entry to check FSBS three times daily, before breakfast scheduled at 7:30am, before lunch scheduled at 11:30am, and before dinner scheduled at 4:30pm. -There was an entry to administer insulin aspart U-100 insulin pen with meals per SSI scale. -There was an entry for SSI for blood sugar with sliding scale blood glucose (BG) 150-200 inject 2 units(U); BG 201-250 = 4units; BG 251-300 = 6U;	D 358		

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D 358	Continued From page 5 BG 301-350 = 8U; BG 351-400 = 10U; and BG 401-450 = 12U. -FSBS values ranged from 84 to 198. -There were 23 opportunities when SSI should have been administered. -There were 8 opportunities when SSI should have been administered but no amount of SSI was documented on the MAR or FSBS binder pages. -Examples were as follows: -On 06/03/25 at 4:30pm, the FSBS was 170 and 2U insulin aspart should have been administered, but no SSI was documented as administered. -On 06/05/25 at 11:30am, the FSBS was 167 and 2U insulin aspart should have been administered, but no SSI was documented as administered. -On 06/11/25 at 4:30pm, the FSBS was 222 and 4U insulin aspart should have been administered, but no SSI was documented as administered. -On 06/23/25 at 4:30pm, the FSBS was 162 and 2U insulin aspart should have been administered, but no SSI was documented as administered. -On 06/24/25 at 4:30pm, the FSBS was 168 and 2U insulin aspart should have been administered, but no SSI was documented as administered. Review of Resident #1's July 2025 MAR from 07/01/25 to 07/29/25 and July 2025 FSBS binder pages revealed: -There was an entry to check FSBS three times daily, before breakfast scheduled at 7:30am, before lunch scheduled at 11:30am, and before dinner scheduled at 4:30pm on the MAR. -There was an entry to administer insulin aspart U-100 insulin pen with meals per SSI scale. -There was an entry for SSI for blood sugar with sliding scale blood glucose (BG) 150-200 inject 2 units(U); BG 201-250 = 4units; BG 251-300 = 6U; BG 301-350 = 8U; BG 351-400 = 10U; and BG 401-450 = 12U.	D 358		

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-FSBS values ranged from 91 to 188.
-There were 11 opportunities when SSI should have been administered.
-There were 2 opportunities when SSI should have been administered but no amount of SSI was documented on the MAR or FSBS binder pages.
-The results were as follows:
-On 07/08/25 at 4:30pm, the FSBS was 154 and 2U insulin aspart should have been administered, but no SSI was documented as administered.
-On 07/27/25 at 7:30am, the FSBS was 151 and 2U insulin aspart should have been administered, but no SSI was documented as administered.

According to the American Diabetes Association a HgAIC (a test used to measure blood glucose values over an extended period) of less than 5.7% is considered normal, 5.7% to 6.4% indicates prediabetes, and 6.5% or higher indicates diabetes.

Review of Resident #1's laboratory results revealed:
-On 03/11/25, the HgA1C value was 7.1.
-On 06/06/25, the HgA1C value was 6.7.

Observation of medications on hand for Resident #1 on 07/30/25 at 2:45 revealed there was a box of 5 pens dispensed on 02/26/25, with one insulin aspart U-100 pen that had been opened on 07/30/25 and one unopened pen.

Telephone interview with the facility's contracted pharmacy on 07/19/25 at 2:58pm revealed:
-Pharmacy staff added orders onto the facility's MARs.
-One box of 5 pens of aspart U-100 was dispensed on 02/26/25 from the order on the FL2 dated 01/08/25.

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D 358	Continued From page 7 -The pharmacy had a recent order dated 03/17/25 insulin aspart U-100 unit/mL (3mL); inject insulin subcutaneously per SSI. Interview with the RCC on 07/30/25 at 2:00pm revealed: -She routinely worked morning shifts at the facility Monday through Friday weekly and some weekends. -Occasionally, she worked morning and evening shifts due to staffing shortages or call-outs. -Resident #1 was the only resident receiving SSI with parameters for administering insulin according to the FSBS values. -She administered Resident #1 insulin aspart according to the sliding scale if the resident's FSBS was over 150. -There were a few of the FSBS values documented when she checked the FSBS value with no SSI amount documented. -She felt certain she administered Resident #1's insulin aspart according to the sliding scale. -She documented the amount of insulin aspart she administered either on the front of the MAR or wrote the amount of insulin aspart administered on the back of the MAR. -If there was no amount of insulin documented on the MAR, she would have no way to verify she administered the insulin. Interview with Resident #1 on 07/30/25 at 3:30pm revealed: -The MAs collected FSBS several times a day, usually before she ate meals. -She received insulin sometimes but not other times. -She did not know when she was supposed to receive insulin from the value of the FSBS. -The MAs knew when she was supposed to receive a shot of insulin before her meal.	D 358		

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D 358	Continued From page 8 Interview with MA on 07/30/25 at 3:40pm revealed: -She routinely worked the evening shift from 3:00pm to 11:00pm. -Sometimes she worked morning shifts (7:00am to 3:00pm). -Resident #1 was the only resident with SSI according to parameters. -She checked Resident #1's FSBS before the dinner meal. -Resident #1's FSBS was usually under 150, but a few times over 150. -Resident #1's rarely needed more than 2 units of insulin aspart. -There were some of the FSBS values identified as times she checked Resident #1's FSBS. -She knew Resident #1 had SSI to be administered if her FSBS was over 151. -She administered insulin aspart to Resident #1 when the FSBS was over 151. -She was supposed to document the amount of insulin aspart on the front of the MAR or on the back of the MAR. -She got really busy around 4:30pm. -She is sure she administered Resident #1's sliding scale insulin aspart, but if she had documented the administration, there was no way prove it. Interview with the facility's nurse on 07/30/25 at 4:00pm revealed: -The MAs were supposed to document the amount of insulin aspart administered according to Resident #1's SSI parameters on the front or back on the MAR. -The MAs were supposed to check behind each other for medication administration and documentation. -She was responsible for reviewing residents'	D 358		

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D 358	Continued From page 9 MARs for ensuring medications were administered as ordered. -She tried to review MARs monthly, but she had fallen behind due to staffing issues. -She had not checked Resident #1's MARs for documentation of FSBS values and insulin aspart administration for May 2025, June 2025, or July 2025. -If Resident #1's insulin aspart was not documented as administered, then there was no way to determine if the resident received the medication. Attempted interview with Resident #1's primary care provider (PCP) on 07/30/25 at 4:05pm was unsuccessful. Interview with the Administrator on 07/30/25 at 4:13pm revealed: -The RCC and the facility's nurse were responsible for checking that entries were correct and complete. -He was not aware that Resident # 1's insulin units were not being administered and entered onto the MARs or on the FSBS binder pages. -He expected MAs to document the number of insulin units administered to residents as ordered, administer the insulin and document administration on the MARs. -If there was not SSI documented it was not possible to determine if Resident #1 received the correct amount of insulin aspart.	D 358		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the	D 367		

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D 367	Continued From page 10 following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to accurately document the administration of medications on the electronic medication administration records (eMAR) for 2 of 5 sample residents related to a controlled substance used to treat pain (#5) and a sleep aide, anti-psychotic and a medication to lower cholesterol (#$). The findings are: 1. Review of Resident #5's current FL-2 dated 06/09/25 revealed: - Diagnoses included muscle weakness, peripheral vascular disease, gastro-esophageal reflux, cognitive communication deficit, dysarthria anarthria, dysphagia, oropharyngeal phase and	D 367		

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glaucoma.
-There was an order for oxycodone HCL 5mg take 1 tablet for pain every 6 hours as needed for pain.

Review of Resident #5's June 2025 controlled substance count sheet (CSCS) revealed:
-There was an entry for Oxycodone HCL 15mg, take 1 tablet every 6 hours as needed (PRN).
-Oxycodone HCL 5mg was documented as administered on 6/30/25 at 9:00am.

Review of Resident #5's June 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Oxycodone HCL 5mg, take 1 tablet every 6 hours as needed.
-There was no documentation of Oxycodone HCL given on 06/30/2025 at 9:00am.

Review of Resident #5's July 2025 CSCS revealed:
-There was an entry for Oxycodone HCL 15mg, take 1 tablet every 6 hours as needed.
-Oxycodone HCL 5mg was documented as administered 07/05/25 at 10:00am, 07/12/25 at 3:00am, 07/13/25 at 3:00am and 07/26/25 at 2:00am

Review of Resident #5's July 2025 eMAR revealed:
-There was an entry for Oxycodone HCL 5mg, take 1 tablet every 6 hours as needed.
-There was no documentation of Oxycodone HCL given 07/05/25 at 10:00am, 07/12/25 at 3:00am, 07/13/25 at 3:00am and 07/26/25 at 2:00am.

Interview with a medication aide (MA) on 07/30/25 at 2:00pm revealed:
-She had administered Oxycodone HCL to

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D 367	Continued From page 12 Resident #5. -She was not aware that she signed Oxycodone 5mg out on the CSCS 07/05/25 at 10:00am but did not sign out as administered on the eMAR on 07/05/25. -Normally, she pulled the medication from the cart, administered it to the resident and signed it out on the eMAR and the CSCS. -She must have gotten distracted and missed it. Interview with a second MA on 07/16/25 at 2:10pm revealed: -He was not aware that he signed Oxycodone 5mg out on the CSCS on 06/30/2025 at 9:00am 07/12/25 at 3:00am, 07/13/25 at 3:00am and 07/26/25 at 2:00am but did not sign out as administered on the eMAR on 06/30/25, 07/12/25, 07/13/25 and 07/26/25 on the eMAR. -MAs were supposed to document the administration of controlled substances in the eMAR and on the CSCS after they were given to the resident. -The dates of administration of medication on the CSCS should match on the eMAR. -He was not sure why he did not document those days in the eMAR. Interview with the facility's nurse on 07/30/25 revealed: -She was not aware MA did not sign Oxycodone out on the eMAR on 06/30/25, 07/05/25, 07/12/25, 07/13/25 and 07/26/25 for Resident # 5 when they were administered. -She expected all MAs to sign out controlled medications on the CSCS and document on the eMAR at the time they were administered to any resident. -She was responsible for monthly chart and eMAR audits. -She had not audited Resident #5's chart	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032071	A. BUILDING: _____ B. WING _____	07/30/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 13	D 367		

because he was a new resident admitted last month.

Interview with the Administrator on 07/30/25 at 2:40pm revealed:
-He was not aware MA did not sign Oxycodone out on the eMAR on 06/30/25, 07/05/25, 07/12/25, 07/13/25 and 07/26/25 for Resident # 5 when they were administered.
-He was glad they signed the CSCS.
-His expectation was that all MAs sign medications out on the CSCS and eMAR when they were administered.

2. Review of Resident #4's current FL2 dated 01/14/25 revealed:
-Diagnoses included dementia, depression, anxiety, insomnia, chronic pain, syncope, and gastric reflux disease.
-There was an order for melatonin 3mg at bedtime.
-There was an order for olanzapine 5mg at bedtime.
-There was an order for atorvastatin 80mg at bedtime.

Review of Resident #4's electronic medication administration record (eMAR) for July 2025 from 07/01/25 to 07/29/25 revealed:
-There was an entry for melatonin 3mg at bedtime with a scheduled administration time of 8:00pm.
-There was no documentation melatonin 3mg at bedtime was administered on 07/17/25, 07/21/25 to 07/24/25, and 07/26/25 to 07/28/25.
-There was an entry for olanzapine 5mg at bedtime with a scheduled administration time of 8:00pm.
- There was no documentation melatonin 3mg at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032071	A. BUILDING: _____ B. WING _____	07/30/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 14	D 367		

bedtime was administered on 07/17/25, 07/21/25 to 07/24/25, and 07/26/25 to 07/28/25.
-There was an entry for atorvastatin 80mg at bedtime with a scheduled administration time of 8:00pm.
- There was no documentation melatonin 3mg at bedtime was administered on 07/17/25, 07/21/25 to 07/24/25, and 07/26/25 to 07/28/25.

Interview with a medication aide (MA) on 07/30/25 at 2:44pm revealed:
-She worked the evening shift.
-She administered Resident #4's medications on 07/17/25, 07/21/25 to 07/24/25, and 07/26/25 to 07/28/25.
-She forgot to sign off on the eMAR after she administered the medications.
-She knew she was supposed to sign off on the eMAR right after medication was administered; she just went right on to the next resident.

Interview with the facility's nurse on 07/30/25 at 2:53pm revealed:
-The MAs knew they were supposed to sign the eMAR immediately after administering a resident's medications.
-She did not know the MA did not sign the eMAR for so many days.
-She did not know why the MA did not sign the eMAR for so many days in July.
-She expected the MAs to sign off the eMAR right after the administered medications before they went on to anything else.

Interview with the Administrator on 0730/25 at 2:40pm revealed he expected MAs to sign off the eMAR after they administered medications.