STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053026	A. BUILDING: _____ B. WING _____	10/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA HOUSE RETIREMENT CENTER	1115 CARTHAGE STREET SANFORD, NC 27330

(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 and complaint investigation on October 19-21, 2016.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to notify the physician for 1 of 5 sampled residents (Resident #2) regarding an order to notify the physician of pulse oximeter values less than 90%. The findings are: Review of Resident #2's current FL2 dated 07/10/16 revealed diagnoses included sepsis secondary to right lower lung pneumonia, possible healthcare associated pneumonia, probable pyelonephritis secondary to Escherichia coli urinary tract infection, vascular dementia and high blood pressure. Review of Resident #2's signed Physician Order sheet dated 09/10/16 revealed: -A diagnosis of hypoxia. -An order to check patient's oxygen saturation (Sat) with pulse oximeter (A device used to measure oxygen saturation in the blood) every 30 minutes times 4, then every 1 hour times 2, then every 2 hours times 2, then every 4 hours times 2, then 4 times a day prior to administering	D 273		

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D 273	Continued From page 1	D 273		

DuoNeb treatments. (DuoNeb is a combination of a short acting and long acting bronchial dilator.)
-Document and notify doctor if oxygen saturation < 90% and do not improve with oxygen.
-There was no order to recheck Sat.
-"Try to provide supplemental oxygen at 2 liters via nasal cannula (NC)".
-"Try to tape NC to patient's cheek with a Tegaderm and encourage her to wear it".

Review of Resident #2's Record revealed:
-A signed medication review dated 09/10/16 continuing the order for pulse oximeter and oxygen and a lab result dated 10/03/16, for carbon dioxide level of 33 (normal 23-29 mEq/l).
-A signed physician's order dated 09/08/16 to encourage Resident #2 to wear oxygen at all times.

Review of Resident #2's September 2016 electronic Medication Administration Record (eMAR) revealed:
-An entry for pulse oximeter, check pulse oximeter 4 times daily prior to administering DuoNebs, document and notify physician if oxygen sats are < (less than) 90% and do not improve with oxygen.
-Pulse oximeter readings were documented seventy-one occasions from 09/13/16 at 12:00 pm to 09/30/16 at 8:00 pm.
-Twenty-three out of the 71 occasions were documented as <90%.
-Examples of pulse oximeter readings of < 90 % were as follows:
-On 09/14/16 at 8:00 pm, Sat = 87%.
-On 09/15/16 at 12:00 pm, Sat = 72%.
-On 09/18/16 at 8:00 pm, Sat = 80%.
-On 09/21/16 at 8:00 am, Sat = 80%.
-On 09/28/16 at 8:00 am, Sat = 84%.
-On 09/14/16 at 8:00 am, Sat was not

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D 273	Continued From page 2 documented. Review of Resident #2's October 2016 eMAR revealed: -An entry for pulse oximeter finger, check pulse oximeter 4 times daily prior to administering Duoneb's, document and notify physician if oxygen Saturations are < 90% and do not improve with oxygen. -There were 77 occasions documented from 10/01/16 at 8:00 am to 10/20/16 at 8:00 am. -Twenty-seven out of the 77 occasions were documented as Sat <90%. -Examples of pulse oximeter readings of <90% were as follows: -On 10/05/16 at 8:00 am, Sat = 87%. -On 10/07/16 at 12:00 pm, Sat = 78%. -On 10/11/16 at 12:00 pm, Sat = 81%. -On 10/12/16 at 4:00 pm, Sat = 89%. -On 10/14/16 at 8:00 am, Sat = 87%. -On 10/14/16 at 12:00 pm, Sat = 89%. -On 10/14/16 at 4:00 pm, Sat = 93%. -On 10/14/16 at 8:00 pm, Sat = 89%. -On 10/20/16 at 8:00 am, Sat = 73%. -On 10/02/16 at 8:00 pm and on 10/04/16 at 8:00 pm, Sats were not documented. -There was no documentation of Sat recheck. Review of Resident #2's record revealed, no documention that the prescriber was notified for pulse oximeter values < 90% in September 2016 or October 2016 from 10/01/16 to 10/13/16. Review of Resident #2's nurses notes dated 10/14/16 revealed: -"Medtech informed nurse of Resident [#2] O2 Sats being 89%, [physician] called and informed", and initials noted. -"At 11:46 also at 9:00 am medtech informed nurse of O2 Sat being at 87%, [physician]	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 273	Continued From page 3 informed", initials noted. Review of Resident #2's Nurses notes dated 10/20/16 revealed; -" (7a - 7p) Resident had a good day", with initials noted. Then next line stated, "but doctor was notified of O2 Sat being that 89 was her O2 level", and no initials noted. -There was another entry for 10/20/16 stating, "Resident O2 Sat was 73% doctor notified", with initial noted. Telephone interview on 10/21/16 at 9:40 am with Hospice Clinical manager revealed: -There was documentation of a dictated nurse's note dated 10/7/16 that stated the Licensed Practical Nurse (LPN) visiting that day found Resident #2 walking around short of breath with labored breathing, while NC on floor in TV room and O2 concentrator machine turned off. -The LPN applied oxygen via NC and sat with Resident #2 until breathing was better and oxygen saturation was above 90%. -There were no documented calls from the facility in regards to Resident #2's low oxygen saturations. Interview on 10/21/16 at 9:35 am with housekeeping staff revealed: -He was responsible for cleaning all of the room in the facility. -He had not ever seen an O2 concentrator in Resident #2's room. -When he cleaned the TV room that there was an O2 concentrator there for Resident #2 to use because she sat there a lot. Interview on 10/21/16 at 9:40 am with Patient Support at Physician's office revealed: -They were aware of Resident #2's	D 273		

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D 273	Continued From page 4	D 273		

non-compliance with using oxygen.
-There was no documentation about oxygen levels dropping below 90%.
-There was documentation for the physician's order dated 09/10/16 to check Resident #2's oxygen saturation and to notify the physician if Sats were below 90%.
-There was a diagnosis of hypoxia for Resident #2.

Interview on 10/21/16 at 9:50 am with the Resident Care Coordinator (RCC) revealed:
-She was aware of Resident #2 getting DuoNeb treatments.
-Resident #2 did not wear her oxygen.
-Her O2 concentrator was in the TV room where Resident #2 was located the majority of the time.
-Her O2 concentrator was placed in Resident #2's room at night.
-Medication Aides were to document per physician's orders.
-The RCC had documentation for some of the physician notification of Sats < 90%.
-The RCC provided the nurses notes dated 10/14/16 and 10/20/16 documenting that the physician had been notified on those dates.

Telephone interview on 10/21/16 at 4:30 pm with Nurse Practitioner (NP) revealed:
-There had been no notes or communications relating to Resident #2's oxygen saturation < 90%.
-Resident #2 had a diagnoses of hypoxia.
-It was her expectation of the facility to call with an oxygen saturation of < 90% due to Resident #2 having a diagnoses of hypoxia.
-An oxygen saturation of < 90% for a short period of time can result in a respiratory distress episode and result in hospitalization.
-An order clarification dated 10/21/16 at 9:56 am

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D 273	Continued From page 5 was sent to facility. Based on record review, and observation on 10/21/16, Resident #2 was determined not to be interviewable. Observation on 10/19/16 at 10:25 am revealed: -Resident #2 sitting in a recliner in the TV room. -The oxygen concentrator was to the left of the resident in the TV room, with NC attached and the machine was turned off. Observation on 10/19/16 revealed: -At 10:30 am, Resident #2 was sitting in the dining room; Resident #2 was not displaying any shortness of breath. -At 4:25 pm, Resident #2 was walking down hallway; Resident #2 was not displaying any shortness of breath. -The oxygen concentrator was in the TV room with NC attached and machine was turned off. Observation on 10/20/16 at 8:17 am revealed: -Resident #2 was walking down hallway outside of her room. -The oxygen concentrator was in the TV room with NC attached and machine was turned off. -There were no other oxygen machine or oxygen tank observed in Resident #2's room. Observation on 10/21/16 at 9:00 am revealed the oxygen concentrator was in the TV room with NC attached and machine was turned off.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record:	D 276		

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D 276	Continued From page 6 (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record review the facility failed to implement orders for blood pressure checks weekly for 1 of 5 sampled residents (Resident #1). The findings are: Review of Resident #1's current FL2 dated 03/21/16 revealed: -Diagnoses included vascular dementia, hallucinations, type II diabetes, schizophrenia, personality disorder, hypokalemia and depression. -An order for lisinopril 2.5 mg (used to treat high blood pressure) 1 daily. -An order for blood pressures to be checked weekly. Review of Resident #1's Resident Register revealed an admission date of 03/21/16. Review of Resident #1's Vital Sign Record revealed: -Blood pressures were taken monthly starting on 03/22/16. -Resident #1's blood pressure ranged from 110/68 to 140/75 from March 2016 to October 2016. -There was no documentation of weekly blood pressure.	D 276		

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D 276	Continued From page 7 Review of Resident #1's March 2016 - October 2016 electronic Medication Administration Records (eMARs) revealed no entries for blood pressures to be checked weekly. Interview on 10/20/16 at 10:27 am with a pharmacy technician for the contract pharmacy revealed: -The facility had been having problems with Wi-Fi connections. -The computers must be synced many times throughout the day in order to update. -Once a medication was given, and the Medication Aide (MA) signed off that the medication was given, the computer time stamped the eMAR, and when the computer was synced, then it showed the correct date and time given. -There had been some issues with data entry on the pharmacy's part. -Resident #1's profile had information missing, and orders that showed up on the eMAR were incomplete, ie; the blood pressure box for weekly was not checked. -When the orders were entered into the eMAR, they showed up the next day for review by the facility. -Any questions or concerns were to be directed to the pharmacy or the physician for clarifications. -There were no calls for clarifications in Resident #1's record at the pharmacy. Interview on 10/20/16 at 11:30 am with a Medication Aide (MA) revealed: -Vital signs were located in a vital sign book at nurse's desk. -The MA was not aware that Resident #1's blood pressure was to be taken weekly. -It has to be on the eMAR in order to get the	D 276		

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D 276	Continued From page 8	D 276		

blood pressures weekly.
-The Resident Care Coordinator (RCC) was responsible for the new orders and sending them to the pharmacy to be added to the eMAR.
-The eMARs were reviewed by the Administrator.
-The MA administered the medications and treatments from the orders on the eMARs.

Interview on 10/20/16 at 11:40 am with the RCC revealed:
-She was not aware that the blood pressure was to be done weekly on Resident #1.
-The vital sign book documented that they were done monthly on Resident #1.
-"I will call the doctor to get an order to cancel the weekly blood pressures starting in March."
-"It's the pharmacy's fault because they did not put it on the MAR."

Interview on 10/21/16 at 9:45 am with Resident #1 revealed:
-He had been at the facility since about the beginning of the year.
-He could not remember getting his blood pressure taken.
-He did not know why he had to get his blood pressure checked.

Interview on 10/21/16 at 11:30 am with the RCC revealed:
-The new orders came in by fax and she then faxed the new orders to the pharmacy.
-All orders were put in the eMAR by the pharmacy.
-The new orders in the eMARs were reviewed by the Administrator at the facility and then released for the Medication Aides (MA) to carry out the orders.
-Any clarifications of the new orders were done by RCC or the Administrator.

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D 276	Continued From page 9 Interview on 10/21/16 at 11:30 am with the Administrator revealed: -The new orders came in by fax. -All orders were put in the eMAR by the pharmacy. -The new orders in the eMAR were reviewed by the Administrator at the facility and then released for the MA to carry out the orders. -The Administrator did not routinely audit the eMARs after the initial review for accuracy. -Any clarifications of the new orders were done by the Administrator or the RCC. Interview on 10/21/16 at 12:48 pm with pharmacy technician from the contract pharmacy revealed: -There was a hard copy signed physician's order dated 04/07/16 for blood pressures to be checked weekly. -There was a hard copy of FL2 dated 03/21/16 with an order to check blood pressures weekly. -Resident #1's profile set in the pharmacy computer did not have the box checked to put the order in the computer for the blood pressures to be checked weekly. -"The fact that the blood pressure box was not checked for weekly checks was a data entry error on their part". -The box is now checked and the blood pressures will now show on the eMAR to be done on a weekly basis. Telephone interview on 10/21/16 at 4:30 pm with Nurse Practitioner revealed: -The order was to check blood pressures on a weekly basis. -The blood pressure order should be followed as written. -She had not written for the blood pressure to be checked on a monthly basis.	D 276		

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D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide a place setting which included a knife, fork, and spoon for 22 of 25 residents. The findings are: Review of the posted lunch menu on 10/19/16 at 11:52 am revealed the lunch included: glazed pork chop, navy beans, mixed vegetables, pineapple upside down cake, corn bread, sweetened/unsweetened tea, milk and ice water. Observation of the lunch meal on 10/19/16 from 11:52 am to 12:50 pm revealed: -Each of the 25 residents in the dining room had a place setting which included a fork and a spoon. -No one received a knife. -Residents were served a pork chop, navy beans, mixed vegetables, corn bread, tea and water. One resident requested and received a pimento cheese sandwich in lieu of the pork chop.	D 287		

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D 287	Continued From page 11 Observation 10/19/16 at 12:10 pm revealed: -A staff member used a knife to cut up the pork chop for the one resident who required feeding assistance. -Correct, appropriate side by side feeding assistance was provided. Observation on 10/19/16 at 12:11 pm revealed: -Another resident requested a knife from a staff member. -The knife was provided, and the staff member stood at the table while the pork shop was cut up by the resident. -The staff member returned the knife to the kitchen. Further observation of the 10/19/16 lunch meal revealed: -The remaining 22 residents each had a pork chop for lunch. -One resident used her hands to tear the pork chop into bite sized pieces and then used her fork to pick up the bite sized pieces. -The remaining residents used their hands to pick up the pork chop and then bit mouthfuls of the meat off the bone. -None of the remaining 22 residents requested a knife. Confidential interviews with 3 residents revealed: -"Sometimes they give us a knife" -"They hardly ever give us a knife". -"I don't know why they don't give us a knife, we don't get one very often" -"It would be much easier to eat if I had a knife to cut up my food". -"Right now we have to pick up the food with our hands or break it apart with our hands". -"It would be easier to eat with a knife".	D 287		

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D 287	Continued From page 12 Interview on 10/20/16 at 4:00 pm with the Head Cook revealed: -"We use knives as needed, it depends on the entree served, if we put out knives for the residents". -"We have enough knives for everyone to have a knife at each mea"l. -"We don't put knives on the table for each meal, because every meal doesn't require a knife". Observation of the kitchen on 10/19/16 at 11:45 am revealed enough knives for each resident to have a knife at the lunch meal. -Interview on 10/21/16 at 11:15 am with the Administrator revealed: -The residents in this locked unit "share everything, even when we don't want them to". -"We don't tell the staff not to use knives, but knives in the dining room could be a safety concern". -"We have enough knives each resident to have a knife at each meal".	D 287		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of	D 299		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA HOUSE RETIREMENT CENTER	1115 CARTHAGE STREET SANFORD, NC 27330

(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 299	Continued From page 13 the product if too much water is used. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to assure milk was served at least twice daily to residents in the Special Care Unit (SCU) facility. The findings are: The entire facility was a SCU. Review of the therapeutic menu dated 10/19/16 revealed residents were to be served milk for lunch and dinner. Observation of the lunch meal on 10/19/16 at 12:00 noon revealed: -25 residents were served in the main dining room. -Each resident was served water and either sweetened or unsweetened tea. -The beverage cart did not contain any milk. -No milk was offered or served. Observation of the lunch meal served small dining room on 10/19/16 at 12:10 revealed: -13 residents were served in the small dining room. -Each resident was served water and either sweetened or unsweetened tea. -No milk was offered or served, no milk was present on the beverage cart. Interview on 10/21/16 at 9:35 am with a resident revealed: -The resident did not drink milk very often. -Milk was available at each meal, but the resident's had to ask for it. -Milk was not served to residents in the same way	D 299		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053026	A. BUILDING: _____ B. WING _____	10/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA HOUSE RETIREMENT CENTER	1115 CARTHAGE STREET SANFORD, NC 27330

(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 299	Continued From page 14	D 299		

that water and tea were served, meaning that tea and water were provided to each resident, but resident's had to ask for milk to be served.

Interview on 10/21/16 at 9:30 am with a second resident revealed:
-"We don't ever get glasses of milk".
-Milk was available, but the residents had to ask staff for a glass of milk.

Interview on 10/21/16 at 10:40 am with a third resident in the SCU revealed:
-"It's not very often they give us milk".
-If a resident wanted milk, they would have to ask a staff member for it and "sometimes you get it and sometimes you don't".

Observation of the kitchen on 10/21/16 at 10:20 am revealed:
-6 unopened gallons of 2% reduced fat milk.
-7 unopened gallons of buttermilk.

Observation of the dinner meal on 10/19/16 at 5:00 pm revealed:
-25 residents ate dinner in the large dining room, none were offered or served milk
-13 residents ate dinner in the small dining room, none were offered or served milk.
-Milk was not on the beverage cart.

Interview on 10/21/16 at 11:00 am with a dining room aide revealed:
-"We serve milk three times a day".
-Milk was served by placing a gallon of milk in a large bowl of ice. The bowl was placed on the beverage serving cart. The cart was pushed into the dining room and milk was offered to the residents in the SCU.
-She did not know why milk was not served or offered to residents during the lunch or dinner

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053026	A. BUILDING: _____ B. WING _____	10/21/2016

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MAGNOLIA HOUSE RETIREMENT CENTER	1115 CARTHAGE STREET SANFORD, NC 27330

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D 299	Continued From page 15 service on 10/19/16, because she did not work that day. Interview on 10/20/16 at 4:00 pm with the Head Cook revealed: -Milk was served to the residents at each meal. -The milk was on the beverage cart and residents could ask for milk to be served. Interview on 10/21/16 at 11:15 am with the Administrator revealed: -Residents are supposed to get milk 2 times each day. -The staff offered milk to residents by putting milk on the beverage cart. -The beverage cart was then taken into the dining room and beverages were served.	D 299		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of 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	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053026	A. BUILDING: _____ B. WING _____	10/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 367	Continued From page 16	D 367		

the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to assure the electronic Medication Administration Records (eMARs) were accurate for 2 of 5 sampled residents for documentation of sliding scale insulin administered (Resident #1) and topical mineral oil (Resident #5).

The findings are:

A. Review of Resident #1's current FL 2 dated 03/21/16 revealed:
-Diagnoses included vascular dementia, hallucinations, type II diabetes, schizophrenia, personality disorder, hypokalemia and depression.
-An order for Humulin R 100 units (a fast acting insulin) sliding scale insulin (SSI) to be given per finger stick blood sugars (FSBS) before meals and at bedtime, with sliding scale parameters of 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, and 351-400 = 10 units.

Review of Resident #1's Resident Register revealed an admission date of 03/21/16.

Review of Resident #1's September 2016 electronic Medication Administration Record (eMAR) revealed:
-An entry for FSBS to be checked 4 times daily before meals and at bedtime from 09/16/16 at 8:00 pm to 09/30/16 at 8:00 pm.
-There was space provided for documenting values and a space for initials.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053026	A. BUILDING: _____ B. WING _____	10/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA HOUSE RETIREMENT CENTER	1115 CARTHAGE STREET SANFORD, NC 27330

(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 17	D 367		

-FSBS results were documented 57 occasions from 09/16/16 at 8:00 pm to 09/30/16 at 8:00 pm.
-Examples of FSBS readings that were documented under the FSBS checks were as follows: 09/17/16 at 7:30 am = 122, 09/20/16 at 4:30 pm = 182, 09/21/16 at 11:30 am = 180, 09/26/16 at 4:30 pm = 200.

Review of Resident #1's September 2016 eMAR revealed:
-An separate entry for Humulin R to be given per SSI, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units.
-There was space provided for documenting values and a space for initials.
-There was no space for documenting the amount of Humulin R administered or the site of administation.
-FSBS results were documented 120 occasions from 09/01/16 at 7:30 am to 09/30/16 at 8:00 pm.
-FSBS values documented for the same time on the entry for Humulin R documentation portion of the eMAR compared to the corresponding time on the FSBS reading were inconsistent.
-There were 28 discrepancies noted compared to the FSBS values documented on the FSBS order.
-The FSBS readings that were documented differently for the FSBS on the insulin administration compared to the FSBS documented on the FSBS checks were as follows: 09/17/16 at 7:30 am = 106, 09/20/16 at 4:30 = 184, 09/21/16 at 11:30 am = 130, 09/26/16 at 4:30 pm =120.
-One occasion was documented as blank on 09/08/16 at 8:00 pm .
-On the 3 occasions that required insulin to be given, there was no documentation for the number of units of Humulin R administered. The occasions were: 09/06/16 at 4:30 pm = 215, 09/15/16 at 11:30 am = 202, and 09/30/16 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053026	A. BUILDING: _____ B. WING _____	10/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA HOUSE RETIREMENT CENTER	1115 CARTHAGE STREET SANFORD, NC 27330

(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 18 11:30 am = 219. Review of Resident #1's October 2016 eMAR revealed: -An entry for FSBS to be checked 4 times daily before meals and at bedtime from 10/01/16 at 7:30 am to 10/20/16 at 7:30 am. -There was space provided for documenting values and a space for initials. -FSBS results were documented 77 occasions from 10/01/16 at 7:30 am to 10/20/16 at 7:30 am. -Examples of FSBS readings that were documented under the FSBS checks were as follows: 10/02/16 at 7:30 am = 130, 10/03/16 at 8:00 pm = 327, 10/04/16 at 7:30 am = 109, 10/07/16 at 8:00 pm = 400, 10/11/16 at 11:30 am = 110, 10/16/16 at 11:30 am = 140, and 10/20/16 at 7:30 am = 721. Review of Resident #1's October 2016 eMAR revealed: -A separate entry for Humulin R to be given per SSI, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units. -There was space provided for documenting values and a space for initials. -There was no space for documenting amount of Humulin R administered or the site of administration. -FSBS results were documented 77 occasions from 10/01/16 at 7:30 am to 10/20/16 at 7:30 am. -FSBS values documented for the same time on the entry for Humulin R documentation portion of the eMAR compared to the corresponding time on the FSBS reading were inconsistent. -There were 40 discrepancies noted compared to the FSBS order documentation. -The FSBS readings that were documented differently for the FSBS on the insulin	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053026	A. BUILDING: _____ B. WING _____	10/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA HOUSE RETIREMENT CENTER	1115 CARTHAGE STREET SANFORD, NC 27330

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D 367	Continued From page 19	D 367		

administration compared to the FSBS documented on the FSBS checks were as follows: 10/02/16 at 7:30 am = 119, 10/03/16 at 8:00 pm = 327, 10/04/16 at 7:30 am = 154, 10/07/16 at 8:00 pm = 400, 10/11/16 at 11:30 am = 98, 10/16/16 at 11:30 am = 112, and 10/20/16 at 7:30 am = 100.
-Two occasions were not documented, 10/09/16 at 4:30 pm, and 10/13/16 at 7:30 am.
-On the 3 occasions that required insulin to be given, there was no documentation for the number of units of Humulin R administered. 10/03/16 at 8:00 pm = = 327, 10/07/16 at 8:00 pm - 400, and 10/13/16 at 8;00 pm = 216.

Interview on 10/20/16 at 11:55 am with Medication Aide (MA) revealed:
-He reviewed the order in the eMAR prior obtaining the FSBS and giving the SSI.
-The FSBS was obtained from the resident.
-The FSBS was documented immediately in 2 places on the eMAR.
-The eMAR was initialed that the FSBS was done in 2 places.
-The resident had only one FSBS checked for the scheduled time.
-The SSI was given according to the order.
-There was no place to document the number of units administered, but he administered the amount SSI according to the order.
-There was no place to document the site of administration.
-The RCC was not informed of the issues with the eMAR documention.
-He cannot explain why there was discrepancies noted in the FSBS values.

Interview on 10/20/16 at 12:35 pm with another MA revealed:
-She only had obtained a FSBS a few times in a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053026	A. BUILDING: _____ B. WING _____	10/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA HOUSE RETIREMENT CENTER	1115 CARTHAGE STREET SANFORD, NC 27330

(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 20	D 367		

month.
-She only worked the medication cart on emergency basis.
-The order was reviewed.
-The FSBS was obtained from the resident.
-The FSBS was documented immediately in 2 places on the eMAR.
-The eMAR was initialed that the FSBS was done in 2 places.
-The SSI was given according to the order only one time in the past two months.
-There was no place to document the number of units administered.
-There was no place to document the site of administration.

Interview on 10/21/16 at 9:45 am with Resident #1 revealed:
-He had been at the facility since about the beginning of the year.
-He does not know why he has to get his blood sugar checked.
-He knew that he got his "sugar" checked every day.

Interview on 10/21/16 at 11:30 am with RCC revealed:
-She was not aware there was no place to document amount of SSI administered or the site of administration on the eMAR for Resident #1.
-The MA staff had not informed her that were not documenting the amount SSI insulin administered or the site of administration on the eMAR for Resident #1.

Interview on 10/21/16 at 12:48 pm with Pharmacy Technician from the contract pharmacy revealed:
-Resident #1's profile set in the pharmacy computer did not have the box checked to put the order in the computer for the amount of insulin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053026	A. BUILDING: _____ B. WING _____	10/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA HOUSE RETIREMENT CENTER	1115 CARTHAGE STREET SANFORD, NC 27330

(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 21	D 367		

administered and a space for the site of administration to be documented
-The fact that the units administered and the site of administration box was not checked, was a data entry error on the part of the pharmacy.
-The technician stated that the box is now checked for units of administered and site of administration, and would now show on the eMAR to be documented as ordered.

Refer to interview on 10/21/16 at 11:30 am with RCC and the Administrator.

B. Review of Resident #5's current FL2 dated 09/11/16 revealed:
-Diagnoses included dementia, hypertension, paranoid schizophrenia, and hematuria.
-An order for mineral oil 2 drops in each ear once weekly.

Observation of Resident #5's medication on hand for administration revealed a 120 ml bottle of mineral oil dispensed (along with a dropper) on 01/15/16 from a local government pharmacy with approximately 110 ml remaining in the bottle.

Review of Resident #5's August, September, and October 2016 electronic Medication Administration Records (eMARs) revealed:
-Mineral oil 2 drops in each ear once weekly at bedtime was listed on the eMAR and scheduled for administration at 7:00 pm on each month.
-Mineral oil 2 drops in each ear once weekly at bedtime was documented as administered at 7:00 pm daily for August 2016, except 08/07/16 was blank for administration and 8/31/16 was documented for refused by the resident.
-Mineral oil 2 drops in each ear once weekly at bedtime was documented as administered at 7:00 pm daily for September 2016, except

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053026	A. BUILDING: _____ B. WING _____	10/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA HOUSE RETIREMENT CENTER	1115 CARTHAGE STREET SANFORD, NC 27330

(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 22 09/10/16 was documented for the resident out of the facility and 09/11/16 was documented for refused by the resident. -Mineral oil 2 drops in each ear once weekly at bedtime was documented as administered at 7:00 pm daily for October 2016 from 10/01/16 to 10/19/16. Interview on 10/20/16 at 10:27 am with a pharmacy technician for the contract pharmacy revealed: -Once a medication was given, and the Medication Aide (MA) signed off that the medication was given, the computer time stamped the EMAR; when the computer was synced, then it would show the date and time given. -There had been some issues with data entry by the pharmacy resulting from staff turnover. -Resident #5's profile had information that showed up on the eMAR for his mineral oil that was incorrect because the order was 2 drops in each ear once weekly, but the order was showing up on the eMAR for administration daily . -Any questions or concerns were to be directed to the pharmacy or the physician for clarifications. -There were no documented calls for correcting the eMAR in Resident #1's record at the pharmacy. -She did random medication cart audits for medications on the carts to be administered compared to the eMAR listing of medications for residents, but she did not audit documentation of administration on the eMARs for accuracy. Interview on 10/19/16 at 3:40 pm with the Resident Care Coordinator (RCC) revealed: -The new orders came in by fax or hand written, and she then faxed the new orders to the pharmacy.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053026	A. BUILDING: _____ B. WING _____	10/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA HOUSE RETIREMENT CENTER	1115 CARTHAGE STREET SANFORD, NC 27330

(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 23 -All orders were entered on the eMAR by the pharmacy. -The Administrator approved and released eMAR orders before the orders appeared for the Medication Aides (MAs) to administer medications. -She routinely audited eMARS for holes (blank administration documentation) but not all medications for accuracy of the time administration compared to the physician's orders. A second interview on 10/21/16 at 10:45 am with the RCC revealed: -The contract pharmacy had entered Resident #5's order in such a way that it was appearing every day on the eMAR instead of one day each week. -The MA staff was incorrectly documenting administration of mineral oil to Resident #5's ear because she was certain Resident #5 did not let anybody administer the ear drops even once a week. -MA staff must have been overlooking the mineral oil drops when the checked off the medications administered to Resident #5. Interview on 10/21/16 at 11:00 am with a MA revealed: -He worked day shifts and evening shifts, depending on the facility staff needs. -Resident #5 does not allow administration of the mineral oil drops to his ears when he attempted to administer the drops. -Resident #5 would become very upset if staff attempted to administer the ear drops. -He recalled that Resident #5 had the ear drops ordered but overlooked that the drops appeared every evening for administration documentation. -He stated MA staff, including himself, could use	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053026	A. BUILDING: _____ B. WING _____	10/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA HOUSE RETIREMENT CENTER	1115 CARTHAGE STREET SANFORD, NC 27330

(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 24 a documentation code for held per physician order to indicated that the medication was appearing on the wrong day but he had not been documenting correctly. Based on record review and observations on 10/20/16 and 10/21/16, Resident #5 was determined not to be interviewable. Refer to interview on 10/21/16 at 11:30 am with the RCC and the Administrator. _____ Interview on 10/21/16 at 11:30 am with the RCC and the Administrator revealed: -The new orders were received by fax or written orders, and RCC then faxed the new orders to the pharmacy. -All orders were put on the eMAR by the pharmacy. -The new orders on the eMARs were reviewed by the Administrator at the facility, and then released for the Medication Aides (MA) to carry out the orders. -Any clarifications of the new orders were done by RCC or the Administrator. -The RCC and Administrator stated the facility had experienced errors in the entry of residents' order to the eMAR by the contract pharmacy, and the pharmacy had corrected some of the entries. -There were still eMAR entries that were not appearing correctly for the MA staff. -The facility was corresponding with the contract pharmacy for corrections when identified.	D 367		