Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING. C B. WING HAL063007 03/30/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 594 MURRAY HILL ROAD **MAGNOLIA GARDENS** SOUTHERN PINES, NC 28387 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 000 Initial Comments D 000 The Adult Care Licensure Section and the Moore County Department of Social Services conducted an annual survey and complaint investigations on March 28-30, 2017. The complaint investigations were initiated by the Moore County Department of Social Services on 02/17/17 and 02/28/17. D 338 10A NCAC 13F .0909 Resident Rights D 338 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21. Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to treat residents with respect, consideration, and dignity, and full recognition of his or her individuality by using the locked Special Care Unit (SCU) to control inappropriate behaviors for 1 of 7 sampled residents (Resident #1) and by failing to provide knives as appropriate for meals for 28 residents in the SCU resulting in residents being unable to cut up their food and not having the necessary eating utensils for consumption of some foods such as meat and vegetables. The findings are: A. Review of Resident #1's current FL2 dated 4/26/16 revealed: -Diagnoses of cerebral vascular accident, dementia, Type 2 diabetes; hypertension; hyperlipidemia; urinary incontinence and congested heart failure. Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDEN/SUPPLIER REPRESENTATIVE'S SIGNATURE

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On 3/2/2017 with a xecution Vice President

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A BUILDING: C B. WING HAL063007 03/30/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 594 MURRAY HILL ROAD **MAGNOLIA GARDENS** SOUTHERN PINES, NC 28387 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 338 Continued From page 1 D 338 -The resident resided in the Assisted Living Unit. -The resident was active in daily activities. -The resident was verbal. -The resident was semi-ambulatory with a walker with wheels. -Medications ordered included trazodone 150 mg at bedtime. (Trazodone used to treat depression). Review of Resident #1's current Personal Care Plan dated 05/01/16 revealed: -Resident #1 received medications for mental illness behaviors. -The resident had a history of mental illness. -The resident was oriented. (To person, place and time was not indicated). -The resident was ambulatory with aide or devices (walker with wheels). -The resident's memory was adequate for daily activities. -The resident was assessed for limited assistance for food preparation, toileting, bathing, dressing, and grooming and hygiene. Review of the Physician Assistant's medical notes dated 11/07/16 revealed: -Staff reported Resident #1 became so disruptive over the weekend that they placed Resident #1 in the Special Care Unit (SCU) for safety. -Resident #1 was reportedly yelling and verbally abusive to staff, and after moved to locked SCU Resident #1 settled down. -Resident #1 reported she was angry with a Medication Aide (MA) and the felt like she wanted to punch the M. -She felt provoked by the MA. -Resident #1 felt she learned her lesson and would not have any further issues. Review of Employee Disciplinary Report dated 11/10/16 revealed:

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING. C B. WNG **HAL063007** 03/30/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **594 MURRAY HILL ROAD MAGNOLIA GARDENS** SOUTHERN PINES, NC 28387 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY** D 338 Continued From page 2 D 338 -Staff A was talked to and written up for reprimanding Resident #1's behavior issue by making her go to a "Time out" in the locked Special Care Unit. -It was signed by the MA and the Administrator on 11/14/16. Interview with the Assistant Director (AD) on 02/16/17 at 3:45 pm revealed: -The AD was not at the facility when the incident happened on 11/06/16. -The resident's family knew Resident #1 and the MA had a love-hate relationship, and that if Resident #1 did not get her way with anyone she would get mad and show out (raise her voice toward staff and residents, go to her room and play music loudly). -The MA told the AD that Resident #1 had been having behavior issues that day. The MA tried to deescalate the behaviors and told Resident #1 if she did not calm down, the MA would be moving her into the SCU to see what it was like. -Resident #1 requested to go to see what it was like. The MA took Resident #1 to the SCU to see what it was like -Resident #1 was back in the SCU for about 5 minutes. -The MA was written up, talked to by the Administrator, and suspended from work for a -Resident #1 started seeing a psychotherapist on 12/15/16 at the facility. The psychotherapist did. not prescribe medication, rather just did therapy every other week. -The psychotherapist then talked to the doctor about Resident #1 and decided what medications Resident #1 should be taking. -Staff knew to redirect Resident #1 when she was having behaviors. (The staff would remove the resident from the current environment, and some

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Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING C B. WNG HAL063007 03/30/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 594 MURRAY HILL ROAD **MAGNOLIA GARDENS SOUTHERN PINES, NC 28387** SUMMARY STATEMENT OF DEFICIENCIES (X4) (D) PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 338 Continued From page 3 D 338 times take the resident to the Administrator or Resident Care Coordinator (RCC) to talk to the resident.) Staff was trained on Behavior Management during new hire orientation. -The AD also said if Resident #1 "got so bad", the staff could bring Resident #1 to the Administrator or the Administrator would go and talk with Resident #1. Interview with Resident #1 on 02/16/17 at 4:40 pm revealed: -She did not like the MA. -The MA "p.... me off". -The MA did what she wants. -Other residents and staff were nice to her. -Her mouth was what got the resident into trouble, that was why she was sent to the SCU. -She was not made or forced to go to the SCU. -She walked back into the SCU on her own and came out on her own when the MA came and got -She had no reason to go to the SCU. -She did get into trouble at the facility for running her mouth and she had been talked to about it. -She was not scared of the MA or any other staff. -The MA was not mean to her. -She was only in the SCU for about 5 minutes. Interview with the RCC on 02/16/17 at 4:55 pm revealed: -Resident #1 was mean to other residents and could be to staff. If Resident #1 did not get her way she "shows out". -Resident #1 had not been able to go out into the community because she was caught stealing things from a local department store. -The MA told the staff Resident #1 wanted to go see what the SCU was like. -The MA said Resident #1 had been having

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	n, the MA would be moving			
Resident #1 into the :	SCU to see what it was like.	1		
-The MA was talked t	o, written up, and			
	Resident #1 in the SCU.			
-All staff was trained	on how to handle upset or	Ī		
mad residents.		į		
-Staff knew to redirec	t Resident #1.			
Pavious of a latter from	n the MA on 03/02/17 dated	1		J
02/27/17 describing the		1		ľ
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-The MA allowed Resi	dent #1 to walk into the			
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Interview with the Adm	inistrator on 03/02/17	T.		
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 She was made aware Resident #1. 	of the situation with	1		
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Cursing and volling. Th	t #1 was having behaviors ne MA tried to deescalate	21		
Resident #1's hehavior	r and if she did not calm			1
down the resident work	ld be moving into the SCU	10		
Resident #1 requested	to go into the SCU and			1
was allowed to on into	the SCU. Resident #1 was			
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-The incident occurred		j		ĺ
weekend and she was	not working.			
-The MA should not ha		1 6		

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	-She talked to the Masuspended her for a -Resident #1 went in came out on her onShe had watched the #1 was in the SCU al -She had never had a family or residentsThe MA talks has a cfirmlyThe MA and Resider relationshipThe MA was never not on Resident #1No one had called he the MA being mean of the MA being mean of the MA training on the Resident #1 was only at the most 10 minute -She had not made Rephysician aware of the Interview with the facilitation of the MA training on the MA the most 10 minute -She had not made Rephysician aware of the MA training on the MA the	A, wrote her up, and day. to the SCU on her on, and She was not forced. e video tape and Resident pout 5 minutes. a complaint on the MA from deep tone voice and talks at #1 had a love-hate mean to any resident and not er and talked to her about r rude. With the MA on 03/21/17 at Behavior Management. If in the SCU for 5 minutes, is esident #1's primary care a resident's behaviors. With the MA on 03/30/17 at are of Resident #1's primary care a resident's behaviors. With the incident by a facility nknown) about 2 weeks priate what the staff did and should not be a place for a pehaviors.				
	Second interview with 03/30/17 at 12:45 pm :					

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	40 - 2-00 -2 00				
	verbally abusive to st 11/06/16. -Resident #1 was onl	ing, cussing and being aff and other residents on y in the SCU for 5 minutes.		To assure Resident Right are not hindered. 13F.0 We have implemented no	909. ew
 -The Physician Assistant was made aware of the situation of Resident #1 after it happened. 			procedures to prevent an	y	
	-Staff was trained on	behavior management (Try ay from a confrontation and		further errors.	
	Telephone interview with Physician Assistant on 03/30/17 at 1:00 PM revealed: -She was notified by the facility about Resident #1's behavior and Resident #1 placed in the Special Care unit by facility staff on 11/07/16Resident #1 also told her she walked into the Special Care Unit on her ownShe felt the staff did the best they could to do to handle the situation at the timeShe did not call the doctor and tell him about Resident #1. She said she saw Resident #1 more for her behaviors then he didResident #1 was seeing a mental health physician beginning in December 2016Resident #1 was not under the care of a Mental Health Provider prior to December 2016.			A. Magnolia Gardens will provide additional training for staff for residents with behavior issues. We will continue to use outside sources such as For immediate assistances, staff will call local law enforcement. Continue current Follow up policy which includes; notifying MD,	
	B. Observation on 03 lunch meal in Special -There were 28 place and forkThe meal consisted once, whole broccoli spisherbet; lemonade and -The food was not cut residents to consumeNo staff were observe offering to cut up the residents.	/28/17 at 12:00 pm of the Care Unit (SCU) revealed: settings of a napkin, spoon, if a whole slice of turkey, ears, sliced tomato, roll, d water. into pieces for the ed assisting residents or esidents' food.		assessing resident for medical concerns, refeto mental health. LCC and LPN will provide monthly monitoring.	er Visction DATE 3/30/17 Cyllian cucinnation Squartin UP 52/7 84:00 pm
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	observation on 03/28, meal in the SCU reveal d: -The food was not cut residents to consumeNo staff were observed offering to cut up the management of the staff were observed offering to cut up the management of the staff were observed offering to cut up the management of the staff was and no facility purposes with meals. Interview on 03/30/17 as shift MA revealed: -The residents do not good the staff cut all food for safety purposesThe staff cut all food for safety purposesThe staff reported no as why knives were not us being in a SCUThe staff confirmed the support not providing the sculport not providing the sculport for providing the sculport for good of the sculport for providing the sculport for good of the sculport for providing the sculport for good of the sculport for good	up the slice of tomato and (17 at 5:30 pm of the dinner aled: settings of a napkin, spoon, if egg salad, tomato is, half a pear; lemonade into pieces for the disassisting residents or esidents' food. coords revealed there were o withhold knives with olicy related to witholding at 8:40 am with the aled the SCU residents did y purposes, but the SCU t all food for the residents. at 8:48 am with the first set knives. or the residents due to aggression or examples for ed; other than residents are were no orders to se residents with knives. It 1:20 pm with a resident	D 338	B. Magnolia Gardens we provide knives to all residents in the Special Care unit unless MD orders state otherwise Special Care Supervise will monitor weekly. Correct particular	al
	meals.	Marie L			

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D 338 Continued From	page 8	D 338		
meal time and it	uld have liked to have a knife at would help to cut up certain n hard to cut up tough foods with I fork			
Observation on 03/30/17 at 1:25 pm of the SCU kitchen storage area revealed only one knife available for 28 residents in the SCU.				
D 358: 10A NCAC 13F .1004(a) Medication Administration		D 358		
(a) An adult care preparation and a prescription and roby staff are in accepta (1) orders by a licepta which are maintain	1004 Medication Administration home shall assure that the administration of medications, non-prescription, and treatments cordance with: censed prescribing practitioner ned in the resident's record; and ection and the facility's policies			
Based on observa interview, the facil were administered prescribing practit observed during n	net as evidenced by: ation, record review and lity failed to assure medications d as ordered by a licensed ioner to 2 of 7 residents (#5, #9) nedication administration scale insulin administration.			
The findings are:				
observation of 2 e during the 11:30 a	ror rate was 6% based on the rrors out of 30 opportunities im medication pass on 03/28/17 ication pass on 03/29/17.			·
A. Review of Res	ident #9's current FL-2 dated			

AND PLANOT CORRECTION AND PLANOT CORRECTION NAME OF PROVIDER OR SUPPLIER MALDS3007 NAME OF PROVIDER OR SUPPLIER MALDS3007 MALDS3007 STREET ADDRESS. CITY, STATE, DP CODE SPA MURRAY HILL ROAD SOUTHERN PINES, N. C 2337 PROVIDER OR SUPPLIER MACROCIA GARDENS SOUTHERN PINES, N. C 2337 PROVIDER OR SUPPLIER MACROCIA GARDENS SOUTHERN PINES, N. C 2337 PROVIDER OR SUPPLIER MACROCIA GARDENS SOUTHERN PINES, N. C 2337 PROVIDER OR SUPPLIER MACROCIA GARDENS SOUTHERN PINES, N. C 2337 PROVIDER OR SUPPLIER MACROCIA GARDENS DESCRIPTION OF PROVIDER OR SUPPLIER MACROCIA GARDENS CONTINUED TO PROVIDER OR SUPPLIER CONTINUED TO PROVIDE TO PROVI	Division of Health Service Regulation					FORM APPROVED
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MARCOF PROVIDER OR SUPPLIER STRICET ADDRESS. CTY. STATE, 2IP CLODE SAMMARY STATEMENT OF DEPOCRATICS SPHAMERY HILL ROAD SOUTHERN PINES, NC 2337 MARCOF PROVIDER'S PLAY OF CORRECTION (KA) D. MECULATORY OR I.SC IDENTIFYING INFORMATION D 358 Continued From page 9 CZZ11177 revealed D-Diagnoses included dispotes melitius, and diabetic peripheral neuropathy An order to administer 8 units of Novolog insulin (a rapid acting insulin) with meals (Novolog's manufacturer states is a fast acting insulin and "10 eat a meal within 5 to 10 minutes after taking I.") An order to theck and record finger slick blood super (FSSS) before meals and administers sliding scale insulin (SSI) Novolog according to parameters : 151-200 = 2 units, 201-250 = 4 units, 251-300-5 units, and greater than 300 = 8 units, Call MD (physician) if FSBS over 400 more than hive. Review of the March 2017 electrone Medication Administration Record (eMAR) revealed: -An entry for 8 units of Novolog insulin subcutaneously with meals was listed on the eMAR and scheduled for administration and 7:30 am, 12:00 pm, and 5:30 pm. An entry to 7 cut such 12:05 4 units, 251-300-5 units, and greater than 300 = 8 units. Call MD (physician) if FSBS over 400 more than wine. An entry to 6 units of TSBS before meals and administer and 7:30 am, 12:00 pm, and 5:30 pm. An entry to check and record FSBS before meals and administer and 7:30 am, 12:00 pm, and 5:30 pm. An entry to check and 7:30 am, 12:00 pm, and 5:30 pm. Novolog insulin 8 units with meals and 2 units before meals and administered at 12:00 pm on 03/28/17. Observation on 03/28/17 at 11:20 am of the Noon medication pass revealed: -The MAR Acconsulted the eMAR Computer monitor	AND PLAN OF CORRECTION	IDENTIFIC	CATION NUMBER:	1		
MACOPURER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MACROCIA GARDENS S94 MURRAY HILL ROAD SOUTHERN PINES, NC 28137 (K4) ID PRETTY RECORDED FYOLI REACH ORDINGS HEAVER CORRECTION (EACH CORRECTION ACTION SHOULD BE RECORDED FY FULL) PRETTY RECORDED TO BE SUBMARY STATEMENT OF DICTIOENCIES PARTY HILL ROAD SOUTHERN PINES, NC 28137 D 358 Continued From page 9 02/21/17 revealed Diagnoses included diabetes melitius, and diabete peripheral neuropathy An order to administer 8 units of Novolog insulin (a rapid acting insulin) with meals. (Novolog's manufacturer states it is a fast acting insulin and "Io eat a meal within 5 to 10 minutes after taking II.") An order to check and rocord finger stick blood sugar (FSBS) before meals and administer silding scale insulin (SS) Novolog according to parameters. 151-200 = 2 units, 201-250 = 4 units, 251-300-5 units, and greater than 300 = 6 units. Call MD (physician) if FSBS over 400 more than twice. Review of the March 2017 electronic Medication Administration Record (eMAR) revealed: An entry for 8 units of Novolog insulin subbulaneously with meals was listed on the eMAR and scheduled for administration at 7:30 am, 12:00 pm, and 5:30 pm. An entry to check and record FSBS before meals and administration at 7:30 am, 12:00 pm, and 5:30 pm. Novolog insulin 8 units with meals and 2 units before meals was documented as administered at 12:00 pm on 03/28/17. Observation on 09/28/17 at 11:20 am of the Noon medication add (MA) obtained a FSBS reading of 200 for Resident #9 -The MA consulted the AMAR computer monitor						
MAGNOLIA GARDENS SUMMARY STATEMENT OF DEPOCHAGE (K4) ID (K4) ID PRETIX ACCHOCARDENS SUMMARY STATEMENT OF DEPOCHAGE (EACH DEPOCHAGENCY MUST BE PRECEDED OF YELL ACCHOCARDENS D 358 Continued From page 9 D 358 D 358 D 2/21/17 revealed: Diagnoses included diabetes melitius, and diabete prepheral neuropathy. An order to administer 8 units of Novolog's manufacturer states it is a fast acting insulin and "to eat a meal within 5 to 10 immutes after taking II.") An order to check and record finger stick blood sugar (FSBS) before meals and administer suliding scale insulir (SSI) Novolog according to parameters 151-200 = 2 units, 201-250 = 4 units, 251-300-5 units, and greater than 300 = 8 units. Call MD (physician) if FSBS over 400 more than twice. Review of the March 2017 electronic Medication Administration Record (eMAR) revealed: An entry for 8 units of Novolog insulin subcutaneously with meals was listed on the eMAR and affectuate for administration at 7:30 pm. An entry to check and record FSBS before meals and administer and administer and forecast present and the eMAR and affectuate the AMR and spreater than 300 = 8 units. Call MD (physician) if FSBS over 400 more than twice was listed on the eMAR and affectuate SSI Novolog according to parameters. 151-200 = 2 units, 201-250 = 4 units, 201-250 = 4 units, 201-250 = 5 units, 201-250 = 4 units, 2		HALO	3007	B. WING		
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medication pass revealed: -The day shift medication aide (MA) obtained a FSBS reading of 200 for Resident #9The MA consulted the eMAR computer monitor	Observation	n 03/28/17 at 11:00		0		
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FSBS reading of 200 for Resident #9The MA consulted the eMAR computer monitor	-The day shift	medication side (MA)	obtained =			1
-The MA consulted the eMAR computer monitor	FSBS reading	of 200 for Resident #6	ootaneo a A			1
for the dose of Novolog insulin to be administered	-The MA cons	ulted the eMAR comp	uter monitor	}		ľ
	for the dose of	Novolog insulin to be	administered			1

Division of Health Service Regulation						FORM APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
'	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
ļ			1			8
			HAL063007	B. WING		C
r						03/30/2017
'	NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE	
١,	MAGNOL	A GARDENS	594 MU	RRAY HILL ROAD		
_			SOUTH	ERN PINES, NC 283	87	
	(X4) ID		ATEMENT OF DEFICIENCIES	טו	PROVIDER'S PLAN OF CORRECT	TION (X5)
	PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	JLD BE COMPLETE
				DAI	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OPRIATE DATE
10 - 00.	D 358	Continued From page	10			· · · · · · · · · · · · · · · · · · ·
	D 300	Continued From page	: 10	D 358		
		to Resident #9.		5		
			d administered 10 units of			
		Novolog insulin to Res	sident #9 at 11:24 am.			
				*		
			at 11:30 am with the day			
		shift MA revealed:				
			SSI were scheduled at			
		he administrated up to	R and medications were to			
		after the time schedule	one hour before or 1 hour			
			cked FSBS values at the			8
		same time every day	starting anytime from 11:15			
		am to 11:30 am.	starting arrytime from 11.15	j		
			ovolog insulin ordered with			
		meals and the Novolo	g insulin based on the SSI			
		parameters to adminis	ter in one insulin shot.			
		-The sliding scale insu	lin was ordered before			
		meals so the insulin w				j
			e resident ate anything.			
			lunch meal around 12:15	2		
		pm to 12:30 pm daily.				
		Observation of Deside	40 02/08/47 (
		11:24 am to 12:38 pm	nt #9 on 03/28/17 from			
			oulating around the facility	E II		2
	81	with no signs of hypogl	lycemia (sweating, shaking,	İ		
		or confusion).	yourna (orreating, orlanding,			
	09	The first bite of the lun	nch meal was at 12:38 pm.			8.
						1
		Interview with Resident	t #9 on 03/28/17 at 12:30			
		pm revealed:		!		
		She was headed to lui	nch.			
		She felt fine.			16	1
	-	ine day shift MA gave	her Novolog insulin today	8		
	:	at about the same time	she usually received her			
		nsulin at lunch. Somel unch.	times it was closer to			
			recent eninedes where the	j		
	-	elt her blood sugges we	recent episodes when she			-
		errater propor sugar was	s low, it usually ran high.	1		
				i)

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED HAL063007 03/30/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **594 MURRAY HILL ROAD MAGNOLIA GARDENS** SOUTHERN PINES, NC 28387 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 358 Continued From page 11 D 358 Refer to interviews on 03/28/17 at 4:40 pm and 03/29/17 at 3:15 pm with the Executive Director. Refer to interviews on 03/28/17 at 5:12 pm and 5:15 pm with 2 medication aides. Refer to interview on 03/29/17 at 11:35 am with the facility's Physician. B. Review of Resident #5's current hospital FL-2 dated 12/30/16 revealed a diagnosis from a current hospitalization was diabetic foot wound. Review of Resident #5's previous FL-2 dated 06/08/16 revealed diagnoses including anxiety. Diabetes Mellitus II, and diabetic foot ulcer. Review of Resident #5's record revealed: -A physician's order dated 01/13/17 order to administer 8 units of Novolog insulin (a rapid acting insulin) with breakfast, lunch, and supper plus sliding scale insulin (SSI) Novolog if blood glucose [measured with finger stick blood sugar (FSBS)] is over 200. (Novolog's manufacturer states it is a fast acting insulin and "to eat a meal within 5 to 10 minutes after taking it.") -The SSI parameters were: sliding scale = 1 unit for every 50 points over 200. Review of Resident #5's record revealed a physician's order dated 02/10/17 to change SSI to new parameters of 1 unit for every 50 FSBS points if blood glucose is over 150. Review of Resident #5's signed physician's orders dated 02/20/17 revealed: -FSBS were ordered 4 times daily at breakfast, lunch, dinner and bedtime. -Novolog insulin Flexpen (a prefilled injection device for administering insulin) 8 units

Division of Health Service Regulation			FORM APPROVED	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		CONSTRUCTION	LYN DATE OFFICE	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING		(X3) DATE SURVEY COMPLETED
		Section of the sectio		2000
	HAL063007	8. WING		С
	Tiracooosi			03/30/2017
NAME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	ITE, ZIP CODE	
MAGNOLIA GARDENS	594 MUI	RRAY HILL ROAD)	
	SOUTH	ERN PINES, NC	28387	
	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ION (X5)
	CY MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL	LD BE COMPLETE
		TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE DATE
D 358 Continued From pag	o 12	5.050		
pag		D 358		
subcutaneously 3 tim				
	eck and record FSBS 3			
times a day with mea	ils and inject per SSI scale:			
151-200 = 1 unit, 201	-250 = 2 units, 251-300 = 3			i i
units, 301-350 = 4 un	its, 351-400 = 5 units.			
Davison of the Mench	2047	1 1		
	2017 electronic Medication			
Administration Record -An entry for 8 units of		8		
	meals was listed on the	78.		
	for administration at 7:30	1		
am, 12:00 pm, and 5:		i i		
	Flexpen check and record			
FSRS 3 times a day in	with meals and inject per SSI	Ì		
scale: 151-200 = 1 ur	oit 201 250 - 2 units	ľ		
	1-350 = 4 units, 351-400 = 5			
	eMAR with scheduled			
	n at 7:30 am, 12:00 pm, and			
5:30 pm.	or construction print care	·		ľ
The second secon	ts with meals and 1 unit			
before meals were bo		1		
	ame time (12:00 pm) on	:		ŀ
03/28/17.	(p, 5	. 1		
Interview on 03/28/17	at 11:30 am with the day			
shift Medication Aide (MA) revealed:			
-Residents' FSBS and	SSI were scheduled at	1		1
12:00 pm on the eMAI	R and medications were to	!		1
be administered up to	one hour before or 1 hour			
after the time schedule		10. E		1
 The MA routinely che 	cked FSBS values at the			
	starting anytime from 11.15	1		
am to 11:30 am.				
-She combined the 8 t	inits of Novolog insulin	i i		
ordered with meals an	d the 2 units of Novolog			
insulin based on the S				į
administer in one insul				
-The sliding scale insu	lin was ordered before	I		
meals so the insulin w		į		i
administered before th	e resident ate anything.	<u> </u>		

Division of Health Service Regulation FORM APPRO				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY
	DENTIFICATION NUMBER.	A. BUILDING:		COMPLETED
	HAL063007	B. WING		C 03/30/2017
NAME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	ZIP CODE	1 00/30/2017
MAGNOLIA GARDENS		RRAY HILL ROAD		
- CARDENO	SOUTH	ERN PINES, NC 28	387	
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D DE COMPLETE
D 358 Continued From page	e 13	D 358		
-The residents ate the pm to 12:30 pm daily	e lunch meal around 12:15			
Observation on 03/28	3/17 at 11:34 am of the Noon	4		
medication pass reve		i		
	ained a FSBS reading of			
170 for Resident #5.	e eMAR computer monitor			
for the dose of Novolo	og insulin to be administered			
to Resident #5.	og madem to be administered	!		
-The MA prepared and administered 9 units of				
Novolog Flexpen insu	lin to Resident #5 at 11:34			
am.				
Observation of Boards				
11:34 am to 12:38 pm	ent #5 on 03/28/17 from			
-The resident was sea		10		
outside the medication	room until around 12:00	1		1
	ining room from 12:00 pm			
until the dining room d	loors opened at 12:20 pm	# #		1
or confusion).	llycemia (sweating, shaking,			
-The first bite of the lui	nch meal was at 12:38 pm.	į		
	it #5 on 03/29/17 at 4:30			
pm revealed: -The MA told her what	her FSBS value was each	į		f
time her blood sugar w		i.		
-She was aware she h		1		
	d not know what the SSI			
	h time SSI from 11:30 am			
to closer to 12:15 pm of	lepending on how busy the			
MA was or which MA w	ras working.	į.		
-She did not recall any	recent episodes when she			1
felt her blood sugar wa				
-Her blood sugar ran hi	igh most of the time.	i		1
Refer to interviews on t	03/28/17 at 4:40 pm and			1
	th the Executive Director.			į

WF5911

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING: COMPLETED C HAL063007 B. WING 03/30/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 594 MURRAY HILL ROAD **MAGNOLIA GARDENS** SOUTHERN PINES, NC 28387 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATIONI CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY D 358 Continued From page 14 D 358 In order to prevent further issues with Refer to interviews on 03/28/17 at 5:12 pm and Medication 5:15 pm with 2 medication aides. Administration 13F .1004, Magnolia Gardens Refer to interview on 03/29/17 at 11:35 am with the facility's Physician. will complete the following: Interviews on 03/28/17 at 4:40 pm and 03/29/17 at 3:15 pm with the Executive Director revealed: -The MAs had received a lot of training on insulin administration due to the importance of administering insulin correctly. -The pharmacy provider had held in-service training on insulin administration for MA staff. -The facility's Quality Assurance (QA) nurse did A. Continue to provide monthly audits for insulin administration. training for MA on -The MAs should be administering SSI according medication admin. to the parameters about 15 minutes before the This training will be resident went to the dining room for their meal. on-line and in person -She was not aware any MAs were administering Novolog insulin more than 30 minutes before the training. All MA resident was served a meal. will receive education by both Interviews on 03/28/17 at 5:12 pm and 5:15 pm our LPN and with 2 medication aides revealed both MAs Pharmacy RN on fast routinely administered any meal time insulin no more than 15 minutes before the resident went to acting insulin. the dining room. Interview on 03/29/17 at 11:35 am with the facility's Physician revealed: Magnolia Gardens' -He was not aware any residents were receiving QI team will rapid acting insulin or SSI more than 30 minutes continue to monitor to one hour before a meal. -He would expect the MA staff to administer rapid med passes and acting insulins 15 to 20 minutes before meals and MAR's monthly. "An hour was definitely too long before a meal". Division of Health Service Regulation STATE FORM 6399

WE5911

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER** CO MPLETED A. BUILDING: C B WING HAL063007 O3/30/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 594 MURRAY HILL ROAD **MAGNOLIA GARDENS** SOUTHERN PINES, NC 28387 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR USC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 438 Continued From page 15 D 438 D 438 10A NCAC 13F .1205 Health Care Personnel D 438 Registry 10A NCAC 13F . 1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13Q .0101 and .0102. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report suspected resident abuse to the Health Care Personal Registry (HCPR) Effective 3/30/2017 within 24 hours of knowledge of the event, and for Magnolia Gardens' failure to complete the 5 day report to HCPR will report any related to allegations a staff (Medication Aide) resident rights placed an Assisted Living Unit resident into the violation to HCPR Special Care Unit (SCU) because of behaviors, on one occasion. within the proper time frame. The findings are: Magnolia Gardens' Interview with Assistant Director (AD) on 02/16/17 Ol team will provide at 3:45 pm revealed: Correction Date

Soffolly

Entelyphene convergetor

Little execution

ON 05/67/17

Had monthly monitor. -Assistant Director was not at the facility when the incident happened on 11/06/16. -The family knew Resident #1 and the Medication Aide (MA) had a love hate relationship and if Resident #1 did not get her way with anyone she got mad and "shows out" -The MA told the AD that Resident # 1 had been having behavior issues that day. The MA tried to deescalate the behaviors and told Resident #1 if she did not calm down she would be moving her into the SCU to see what it was like. -Resident #1 requested to go to see what it was like. The MA took Resident #1 to the SCU to see what it was like.

WF5911

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ COMPLETED HAL063007 B. WING O3/30/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 594 MURRAY HILL ROAD **MAGNOLIA GARDENS** SOUTHERN PINES, NC 28387 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 438 Continued From page 16 D 438 -Resident #1 was back in the SCU for about 5 minutes. -The MA was written up, talked to by the Administrator and suspended from work a day. -Resident #1 started seeing a psychotherapist on 12/15/16 at the facility. The psychotherapist did not prescribe medication, rather does therapy every other week. -The psychotherapist then talks to the doctor at the facility about Resident #1 and decides what medications Resident #1 should be taking. -Staff knew to redirect Resident #1 when she was having behaviors (try to remove the resident from the confrontational situation, and redirect to another area). -Staff was trained on Behavior Management during new hire orientation. -If Resident #1 "got so bad", the staff could bring Resident #1 to the Administrator or the Administrator would talk with Resident #1. Interview with Resident #1 on 02/16/17 at 4:40 pm revealed: -Resident #1 did not like MA. - Medication Aide "pisses me off", -The resident did what she wants. -Other residents and staff were nice to her. -Her "Mouth was what got her into trouble". -That was why she was sent to the SCU on 11/06/16. -She was not made or forced to go to the SCU. -She walked back into the SCU on her own and came out on her own, when the MA came, she entered the pass code and got her out of the SCU. -The resident had no reason to go to the SCU. -She did get into trouble at the facility for running her mouth and she had been talked to about it by the Resident Care Coordinator (RCC), the Administrator, the Nurse Practitioner, and MAs.

Division of Health Service Regulation

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DA'TE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED HAL063007 B. WING 013/30/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 594 MURRAY HILL ROAD **MAGNOLIA GARDENS** SOUTHERN PINES, NC 28387 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 438 Continued From page 17 D 438 -The resident was not scared of the MA or any other staff. -The MA was not mean to her. -The resident was only in the SCU for about 5 minutes. Interview with RCC on 02/16/17 at 4:55 pm revealed: -Resident #1 was mean to other residents and could be to staff. If Resident #1 did not get her way she "showed out". -Resident #1 had not been able to go out into the community because she was caught stealing things from a local department store -The MA told the RCC and the Administrator that Resident #1 wanted to go see what the SCU was like. -Resident #1 had been having behavior issues that day. The MA tried to deescalate the behaviors and told Resident #1 if she did not calm down the MA would be moving the resident into the SCU to see what it was like. -The MA was talked to, written up, and suspended for a day, for putting Resident #1 in the SCU. -Staff was trained on how to handle upset or mad residents. -Staff knew to redirect Resident #1 (move the resident from the confrontational event). Interview with the Administrator on 03/02/17 around 3:05 pm revealed: -It happened at night and on a weekend and when she was not working. -She was made aware of the situation with Resident #1 on the Monday (11/07/16) after the event on Sunday (11/06/16). -The MA should not have done that. -She talked to MA, wrote her up and suspended her for 1 day.

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l	STATEMENT OF DEFICE	ENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	
	AND PLAN OF CORREC	TION	IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DATE SURVEY COMPLETED
l			HAL063007	B. WING		С
Γ	MANUS OF BOOK PAGE A		<u> </u>			03/30/2017
l	NAME OF PROVIDER OF	R SUPPLIER	STREET	ODRESS, CITY, STATE	E, ZIP CODE	
	MAGNOLIA GARDE	NS		RRAY HILL ROAD		
्				ERN PINES, NC 28	387	
	(X4) ID PREFIX (E	SUMMARY ST ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	10	PROVIDER'S PLAN OF CORRECT	CTION (X5)
	TAG RE	GULATORY OR	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE COMPLETE
				-1	DEFICIENCY)	OPRIATE DATE
	D 438 Continue	ed From page	≥ 18	D 438	-	
		B) (50)		. 5 430		
	-Resider	it#) went int	o the SCU on her own, and	i		
	not force		on her on her own. She was			
			video tape and Resident	1		
	#1 was in	the SCII at	out 5 minutes.	3		
	-She had	never had a	previous complaint on the			
	MA from	family or res	idents			
			oice that projected loudly			
	and could	d appear to b	e stern at times to	'		
	residents					
	-The MA	and Residen	t #1 had a love-hate			
	relations					
			ean to any residents and			
not to Resident #1.				Ī		
 No one had called her and talked to her about the MA being mean, or rude. 				j		
	THE WIN DO	ang mean, o	rruge,			
	Telephone	e Interview w	ith the Administrator on	i İ		
	3/16/17 a	2:10 pm rev	ealed:			
			the MA to HCPR.			
	-She did r	ot report it to	the HCPR because	10		
	Resident i	#1 was comp	etent; she walked back to	1		1
	the SCU o	on her own, a	and came out of the SCU			1
	on her ow			ì		
		ild not have		10		
	-She comp	pleted her ini	ernal Investigation and the			
	day.	iiked to, writt	en up and suspended for a			1
	uay.					
	Second in	erview with	Administrator on 03/28/17			ł
		n revealed:	101111111111111111111111111111111111111	i		
			the MA to HCPR yet.	!	2	
	-She had t	he paper wo	rker filled out and ready to	E.		
	be faxed.		3000-	E .		
	-She felt th	at she had c	lone her own investigation,			
	disciplined	the staff, an	d she did not have to			
	report the i					
				×.		
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Šİ	on of Health Service Red	culation				