Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063007	A. BUILDING _____ B. WING _____	C 03/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GARDENS	594 MURRAY HILL ROAD SOUTHERN PINES, NC 28387

(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 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 000		
D 338	10A NCAC 13F .0909 Resident Rights 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.	D 338		

Reviewed and accepted Addendums per telephone on 5/2/2017 with Executive Vice President
HRP

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-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 06/01/16 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 assesed 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:

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-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 day.
-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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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 her.
-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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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 Resident #1 into the SCU to see what it was like.
-The MA was talked to, written up, and suspended for putting Resident #1 in the SCU.
-All staff was trained on how to handle upset or mad residents.
-Staff knew to redirect Resident #1.

Review of a letter from the MA on 03/02/17 dated 02/27/17 describing the event on 11/06/16 revealed:
-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.
-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.
-The MA allowed Resident #1 to walk into the SCU for a visit.
-Resident #1 was only in the SCU for about 5 minutes.

Interview with the Administrator on 03/02/17 around 3:05 PM revealed.
-She was made aware of the situation with Resident #1.
-On 11/06/17 Resident #1 was having behaviors cursing and yelling. The MA tried to deescalate Resident #1's behavior and if she did not calm down the resident would be moving into the SCU Resident #1 requested to go into the SCU and was allowed to go into the SCU. Resident #1 was in the SCU for 5 minutes.
-The incident occurred at night and on the weekend and she was not working.
-The MA should not have done that.

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-She talked to the MA, wrote her up, and suspended her for a day.
-Resident #1 went into the SCU on her on, and came out on her on. She was not forced.
-She had watched the video tape and Resident #1 was in the SCU about 5 minutes.
-She had never had a complaint on the MA from family or residents.
-The MA talks has a deep tone voice and talks firmly.
-The MA and Resident #1 had a love-hate relationship.
-The MA was never mean to any resident and not to Resident #1.
-No one had called her and talked to her about the MA being mean or rude.

Telephone interview with the MA on 03/21/17 at 10:30 am revealed:
-She had training on Behavior Management.
-Resident #1 was only in the SCU for 5 minutes, at the most 10 minutes.
-She had not made Resident #1's primary care physician aware of the resident's behaviors.

Interview with the facility's Doctor on 03/30/17 at 12:30 revealed:
-He was not made aware of Resident #1's behavior the day it happened.
-He was made aware of the incident by a facility staff member (name unknown) about 2 weeks after the incident.
-He felt it was inappropriate what the staff did and the Special Care Unit should not be a place for a resident to be put for behaviors
-He knew Resident #1 and knew she had behavior issues.

Second interview with the Administrator on 03/30/17 at 12:45 pm revealed:

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-Resident #1 was hitting, cussing and being verbally abusive to staff and other residents on 11/06/16.
-Resident #1 was only in the SCU for 5 minutes.
-The Physician Assistant was made aware of the situation of Resident #1 after it happened.
-Staff was trained on behavior management (Try to walk a resident away from a confrontation and redirect to other activity).

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 11/07/16.
-Resident #1 also told her she walked into the Special Care Unit on her own.
-She felt the staff did the best they could to do to handle the situation at the time.
-She did not call the doctor and tell him about Resident #1. She said she saw Resident #1 more for her behaviors then he did.
-Resident #1 was seeing a mental health physician beginning in December 2016.
-Resident #1 was not under the care of a Mental Health Provider prior to December 2016.

B. Observation on 03/28/17 at 12:00 pm of the lunch meal in Special Care Unit (SCU) revealed:
-There were 28 place settings of a napkin, spoon, and fork.
-The meal consisted of a whole slice of turkey, rice, whole broccoli spears, sliced tomato, roll, sherbet; lemonade and water.
-The food was not cut into pieces for the residents to consume.
-No staff were observed assisting residents or offering to cut up the residents' food.
-Several residents picked up the slice of turkey and ate with their hands.

To assure Resident Rights are not hindered. 13F .0909. We have implemented new procedures to prevent any further errors.

A. Magnolia Gardens will provide additional training for staff for residents with behavior issues. We will continue to use outside sources such as [redacted] For immediate assistances, staff will call local law enforcement.

Continue current Follow up policy which includes; notifying MD, assessing resident for medical concerns, refer to mental health.

LCC and LPN will provide monthly monitoring.

correction DATE 3/30/17 per telephone conversation with Executive VP 5-2-17 @ 4:00 pm HRP

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D 338	Continued From page 7 -One resident picked up the slice of tomato and ate it with their hands. Observation on 03/28/17 at 5:30 pm of the dinner meal in the SCU revealed: -There were 28 place settings of a napkin, spoon, and fork. -The meal consisted of egg salad, tomato mozzarella salad, chips, half a pear; lemonade and water. -The food was not cut into pieces for the residents to consume. -No staff were observed assisting residents or offering to cut up the residents' food. Review of residents' records revealed there were no physicians' orders to withhold knives with meals and no facility policy related to witholding knives with meals. Interview on 03/30/17 at 8:40 am with the Assistant Director revealed the SCU residents did not get knives for safety purposes, but the SCU staff used a knife to cut all food for the residents. Interview on 03/30/17 at 8:48 am with the first shift MA revealed: -The residents do not get knives. -The staff cut all food for the residents due to safety purposes. -The staff reported no aggression or examples for why knives were not used; other than residents being in a SCU. -The staff confirmed there were no orders to support not providing the residents with knives. Interview on 03/30/17 at 1:20 pm with a resident in the SCU revealed: -The facility only allowed a spoon and fork at meals.	D 338	B. Magnolia Gardens will provide knives to all residents in the Special Care unit unless MD orders state otherwise. Special Care Supervisor will monitor weekly. Correction DATE 3/30/17 per telephone conversation c Executive VP on 5-2-17 @ 4:00pm ifrp	

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D 338	Continued From page 8 -The resident would have liked to have a knife at meal time and it would help to cut up certain foods. It was often hard to cut up tough foods with only a spoon and 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 338		
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 observation, record review and interview, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner to 2 of 7 residents (#5, #9) observed during medication administration regarding sliding scale insulin administration. The findings are: The medication error rate was 6% based on the observation of 2 errors out of 30 opportunities during the 11:30 am medication pass on 03/28/17 and 7:00 am medication pass on 03/29/17. A. Review of Resident #9's current FL-2 dated	D 358		

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02/21/17 revealed:
-Diagnoses included diabetes mellitus, and diabetic 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 "to eat a meal within 5 to 10 minutes after taking it.")
-An order to check and record finger stick blood sugar (FSBS) before meals and administer 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 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 scheduled for administration at 7:30 am, 12:00 pm, and 5:30 pm.
-An entry to check and record FSBS before meals and administer 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 was listed on the eMAR with scheduled times of 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 03/28/17 at 11:20 am of the Noon medication pass revealed:
-The day shift medication aide (MA) obtained a FSBS reading of 200 for Resident #9.
-The MA consulted the eMAR computer monitor for the dose of Novolog insulin to be administered

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to Resident #9.
-The MA prepared and administered 10 units of Novolog insulin to Resident #9 at 11:24 am.

Interview on 03/28/17 at 11:30 am with the day shift MA revealed:
-Residents' FSBS and SSI were scheduled at 12:00 pm on the eMAR and medications were to be administered up to one hour before or 1 hour after the time scheduled on the eMAR.
-The MA routinely checked FSBS values at the same time every day, starting anytime from 11:15 am to 11:30 am.
-She combined the Novolog insulin ordered with meals and the Novolog insulin based on the SSI parameters to administer in one insulin shot.
-The sliding scale insulin was ordered before meals so the insulin would need to be administered before the resident ate anything.
-The residents ate the lunch meal around 12:15 pm to 12:30 pm daily.

Observation of Resident #9 on 03/28/17 from 11:24 am to 12:38 pm revealed:
-The resident was ambulating around the facility with no signs of hypoglycemia (sweating, shaking, or confusion).
-The first bite of the lunch meal was at 12:38 pm.

Interview with Resident #9 on 03/28/17 at 12:30 pm revealed:
-She was headed to lunch.
-She felt fine.
-The day shift MA gave her Novolog insulin today at about the same time she usually received her insulin at lunch. Sometimes it was closer to lunch.
-She did not recall any recent episodes when she felt her blood sugar was low, it usually ran high.

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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

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subcutaneously 3 times a day with meals.
-Novolog Flexpen check and record FSBS 3 times a day with meals and inject per SSI scale: 151-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 4 units, 351-400 = 5 units.

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 scheduled for administration at 7:30 am, 12:00 pm, and 5:30 pm.
-An entry for Novolog Flexpen check and record FSBS 3 times a day with meals and inject per SSI scale: 151-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 4 units, 351-400 = 5 units was listed on the eMAR with scheduled times of administration at 7:30 am, 12:00 pm, and 5:30 pm.
-Novolog insulin 8 units with meals and 1 unit before meals were both documented as administered at the same time (12:00 pm) on 03/28/17.

Interview on 03/28/17 at 11:30 am with the day shift Medication Aide (MA) revealed:
-Residents' FSBS and SSI were scheduled at 12:00 pm on the eMAR and medications were to be administered up to one hour before or 1 hour after the time scheduled on the MAR.
-The MA routinely checked FSBS values at the same time every day, starting anytime from 11:15 am to 11:30 am.
-She combined the 8 units of Novolog insulin ordered with meals and the 2 units of Novolog insulin based on the SSI parameters to administer in one insulin shot.
-The sliding scale insulin was ordered before meals so the insulin would need to be administered before the resident ate anything.

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	HAL063007	A. BUILDING: _____ B. WING _____	C 03/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GARDENS	594 MURRAY HILL ROAD SOUTHERN PINES, NC 28387

(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
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-The residents ate the lunch meal around 12:15 pm to 12:30 pm daily.

Observation on 03/28/17 at 11:34 am of the Noon medication pass revealed:
-The day shift MA obtained a FSBS reading of 170 for Resident #5.
-The MA consulted the eMAR computer monitor for the dose of Novolog insulin to be administered to Resident #5.
-The MA prepared and administered 9 units of Novolog Flexpen insulin to Resident #5 at 11:34 am.

Observation of Resident #5 on 03/28/17 from 11:34 am to 12:38 pm revealed:
-The resident was seated in the sitting area outside the medication room until around 12:00 pm, and outside the dining room from 12:00 pm until the dining room doors opened at 12:20 pm with no signs of hypoglycemia (sweating, shaking, or confusion).
-The first bite of the lunch meal was at 12:38 pm.

Interview with Resident #5 on 03/29/17 at 4:30 pm revealed:
-The MA told her what her FSBS value was each time her blood sugar was checked.
-She was aware she had fairly new SSI parameters, but she did not know what the SSI parameters were.
-She received her lunch time SSI from 11:30 am to closer to 12:15 pm depending on how busy the MA was or which MA was working.
-She did not recall any recent episodes when she felt her blood sugar was low.
-Her blood sugar ran high most of the time.

Refer to interviews on 03/28/17 at 4:40 pm and 03/29/17 at 3:15 pm with the Executive Director.

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D 358	Continued From page 14 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. 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 monthly audits for insulin administration. -The MAs should be administering SSI according to the parameters about 15 minutes before the resident went to the dining room for their meal. -She was not aware any MAs were administering Novolog insulin more than 30 minutes before the resident was served a meal. Interviews on 03/28/17 at 5:12 pm and 5:15 pm with 2 medication aides revealed both MAs routinely administered any meal time insulin no more than 15 minutes before the resident went to the dining room. Interview on 03/29/17 at 11:35 am with the facility's Physician revealed: -He was not aware any residents were receiving rapid acting insulin or SSI more than 30 minutes to one hour before a meal. -He would expect the MA staff to administer rapid acting insulins 15 to 20 minutes before meals and "An hour was definitely too long before a meal".	D 358	In order to prevent further issues with Medication Administration 13F .1004, Magnolia Gardens will complete the following: A. Continue to provide training for MA on medication admin. This training will be on-line and in person training. All MA will receive education by both our LPN and Pharmacy RN on fast acting insulin. Magnolia Gardens' QI team will continue to monitor med passes and MAR's monthly. correction DATE of 4/07/17 per telephone conversation with the executive director 5.2.2017	

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D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .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) within 24 hours of knowledge of the event, and for failure to complete the 5 day report to HCPR related to allegations a staff (Medication Aide) placed an Assisted Living Unit resident into the Special Care Unit (SCU) because of behaviors, on one occasion. The findings are: Interview with Assistant Director (AD) on 02/16/17 at 3:45 pm revealed: -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.	D 438	Effective 3/30/2017 Magnolia Gardens' will report any resident rights violation to HCPR within the proper time frame. Magnolia Gardens' QI team will provide monthly monitor. Correction Date is 03/30/17 per telephone conversation with executive vice President on 05/02/17 HW	

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-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.

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-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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-Resident #1 went into the SCU on her own, and came out of the SCU on her on her own. She was not forced.
-She had watched the video tape and Resident #1 was in the SCU about 5 minutes.
-She had never had a previous complaint on the MA from family or residents.
-The MA had a deep voice that projected loudly and could appear to be stern at times to residents.
-The MA and Resident #1 had a love-hate relationship
-The MA was never mean to any residents and not to Resident #1.
-No one had called her and talked to her about the MA being mean, or rude.

Telephone Interview with the Administrator on 3/16/17 at 2:10 pm revealed:
-She had not reported the MA to HCPR.
-She did not report it to the HCPR because Resident #1 was competent; she walked back to the SCU on her own, and came out of the SCU on her own.
-This should not have happened.
-She completed her Internal Investigation and the MA was talked to, written up and suspended for a day.

Second interview with Administrator on 03/28/17 at 11:00 am revealed:
-She had not reported the MA to HCPR yet.
-She had the paper worker filled out and ready to be faxed.
-She felt that she had done her own investigation, disciplined the staff, and she did not have to report the incident.