

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL031019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/16/2020
--	--	--	---

NAME OF PROVIDER OR SUPPLIER THE GARDENS OF ROSE HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 517 S SYCAMORE STREET, HWY 117 ROSE HILL, NC 28458
---	--

(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 January 14-16, 2020.	D 000	D 000 Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report; the plan of correction is prepared solely as a matter of compliance with state law.	
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to protect food from contamination and maintain the cleanliness of the kitchen and food storage areas. The findings are: Review of the local county environmental health report dated 12/10/19 revealed: -The door freezer had condensation leaking and forming ice inside the freezer unit. -There was additional cleaning needed inside some of the refrigerator units. Observation of the first refrigerator unit near the juice dispenser on 01/14/20 at 2:43 pm revealed: -There were three metal shelves with rusty areas throughout the shelves. -The metal shelves stored cheeses, eggs, deli meats, and sausages. -There was an undated storage bag of green beans on the bottom shelf. -There was an opened and undated box with an	D 282	D 282 1/14/2020 Freezer and refrigerators cleaned, interior and exterior. Opened, undated items discarded. 1/15/2020 In-service with dietary staff included; -Daily and weekly cleaning schedules and checklists. -Proper storage and dating of food items. -Reporting of equipment damage and/or repair needed. 1/16/2020 Freezer condensation and refrigerator shelving entered into maintenance work order system.	1/14/20 1/15/20 1/16/20

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Francis D. Henon

TITLE

Executive Director

(X6) DATE

2/17/2020

STATE FORM

EWHC11

If continuation sheet 1 of 26

*POC reviewed and accepted
2/24/2020
D. Dawson-Rogers*

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL031019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/16/2020
--	--	--	---

NAME OF PROVIDER OR SUPPLIER
THE GARDENS OF ROSE HILL

STREET ADDRESS, CITY, STATE, ZIP CODE
**517 S SYCAMORE STREET, HWY 117
ROSE HILL, NC 28458**

(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 282	Continued From page 1 opened plastic bag of sausage links on the bottom shelf. -There was an undated storage bag of cheese on the top shelf. -There was an opened plastic package of deli meat on the top shelf that was not in a storage bag and not dated. Observation of the second refrigerator unit on the left side of the dry storage entrance door on 01/14/20 at 2:50 pm revealed: -There were two opened and undated plastic bags filled with parsley that was yellowing. -There were three metal shelves with rusty areas throughout the shelves. Observation of the third refrigerator unit on the right side of the dry storage entrance door on 01/14/20 at 2:52 pm revealed there were two metal shelves with rusty areas throughout the shelves. Observation of the double sided gas oven on 01/14/20 at 3:03 pm revealed: -There were eleven knobs above the oven doors that were sticky to the touch and covered with a brownish greasy residue. -There were blackened areas along the inner walls, floor and door of both ovens. -The edges of the oven doors were covered with a brownish residue. -There were crumbs and brownish stains on the lower outer portion of both ovens. Observation of the double door freezer unit on 01/14/20 at 3:06 pm revealed: -There was condensation around both doors of the freezer. -There was a block of ice in the center of the top shelf of the freezer.	D 282	D 282 cont. Monday-Friday - Ongoing The administrator will review daily and weekly kitchen checklists with dietary manager each morning. x30 Days Administrator to conduct random inspections of kitchen areas daily to ensure daily and weekly checklists are completed. x1 Weekly - Ongoing Administrator to conduct random inspections of kitchen areas weekly to ensure daily and weekly checklists are completed. x1 Weekly - Ongoing Administrator to meet with facility maintenance technician to convey and or follow up any issues in kitchen.	1/16/20 2/14/20 2/14/20 2/14/20

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL031019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/16/2020
--	--	--	---

NAME OF PROVIDER OR SUPPLIER THE GARDENS OF ROSE HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 517 S SYCAMORE STREET, HWY 117 ROSE HILL, NC 28458
---	--

(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 282	<p>Continued From page 2</p> <ul style="list-style-type: none"> -There was a block of ice in the center of the second shelf of the freezer. -There were two undated storage bags of meat on the third shelf of the freezer. -There was an opened and undated plastic bag of sausage patties on the third shelf of the freezer. <p>Observation of the microwave on 01/14/20 at 3:11 pm revealed:</p> <ul style="list-style-type: none"> -There was a seal around the inner rim and front edges of the microwave that was deteriorating and had broken, missing pieces. -There was rust along the metal edges on the right side of the microwave. -There were stains on the inner upper portion of the microwave. -There were stains and brown spots on the vents in the rear of the microwave. <p>Interview with a cook on 01/14/20 at 3:57 pm revealed:</p> <ul style="list-style-type: none"> -She did not work in the kitchen daily and her primary job was transportation. -She was filling in for the dietary manager (DM) for the day. -She had been shown some things by the DM, but she did not recall the date. -She did not know of any cleaning schedule for the kitchen. -She cleaned up the areas she used when cooking such as the stove top, food prep areas, floors, and dishwashing area. -She did not know the last time the oven or freezer were cleaned. -She did not know who opened the box of sausage links, cheese, green beans, parsley, bag of sausage patties or the meat. -She knew to date opened food items and store the foods in a sealed container or storage bag. 	D 282		
-------	---	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL031019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/16/2020
--	--	--	---

NAME OF PROVIDER OR SUPPLIER THE GARDENS OF ROSE HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 517 S SYCAMORE STREET, HWY 117 ROSE HILL, NC 28458
---	--

(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 282	<p>Continued From page 3</p> <p>Interview with a dietary aide on 01/16/20 at 8:58 am revealed:</p> <ul style="list-style-type: none"> -She had worked in the kitchen for eight months and followed the instructions provided by the DM. -She cleaned the dining room, floors, dishwashing area, and the microwave if she spilled something inside. -She did not clean the oven because that was the DM's responsibility. -The freezer had not worked well during the time she worked there and she removed ice from the unit when the DM told her to do so. -She did not know of any cleaning schedule for the kitchen. -She did not open or store any food items. <p>Interview with the DM on 01/15/20 at 10:16 am revealed:</p> <ul style="list-style-type: none"> -She was responsible for the operations in the kitchen. -She was not at work due to illness and she did not know who stepped in to work in the kitchen. -She had three staff and one of those three had another job assignment as the transportation staff. -The staff who worked as the transportation staff had worked more frequently in the kitchen for the past month due to staff shortages in the kitchen. -She needed four kitchen staff in addition to herself. -She knew the freezer was not working properly and was noted on the county environmental health report each time they came to the facility. -She told the Administrator about the double door freezer in December 2019 but he did not discuss what would be done to fix the freezer. -She cleaned the oven three weeks ago with a scrub brush and oven cleaner. -She cleaned the oven when she had time available to do so because they were short 	D 282		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL031019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/16/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER THE GARDENS OF ROSE HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 517 S SYCAMORE STREET, HWY 117 ROSE HILL, NC 28458
--	--

(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 282	<p>Continued From page 4</p> <p>staffed and sometimes, she worked alone in the kitchen.</p> <p>-She tried to clean the knobs above the oven but she had not cleaned them since the summer of 2019.</p> <p>-The microwave was used daily and they wiped it down daily.</p> <p>-The microwave was an older piece of equipment like the oven.</p> <p>-She did not know the vents were not clean, or the rust had formed on the inner edge of the microwave because she was so busy running other aspects of the kitchen.</p> <p>-She had not discussed the microwave with the Administrator.</p> <p>-She completed a cleaning schedule when she was fully staffed but as soon as she made a cleaning schedule staff often left the job.</p> <p>-She taught staff some things when they started but felt that there was other food related and kitchen cleaning items she wanted to teach, but did not have time to teach because she was working as the cook and dietary staff.</p> <p>-She taught staff to date and store food items with dates.</p> <p>-She did not know who opened the sausage, cheese, green beans, or meat because she was not at work on 01/14/20 and 01/15/20.</p> <p>-If she had enough staff, she would clean the freezer and oven weekly.</p> <p>-She knew the metal shelves in the refrigerator were rusted.</p> <p>-In the past, once a year the shelves were taken out of the refrigerator and spray painted, but she did not recall the date this was last done.</p> <p>-She had not told the Administrator about the refrigerator shelves.</p> <p>Interview with the Administrator on 01/16/20 at 9:32 am revealed:</p>	D 282		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL031019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/16/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER THE GARDENS OF ROSE HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 617 S SYCAMORE STREET, HWY 117 ROSE HILL, NC 28458
--	--

(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 282	<p>Continued From page 5</p> <ul style="list-style-type: none"> -He entered and walked through the kitchen once a day. -When he came in the kitchen, he looked at the cleanliness of the floor, uncovered foods, any overflowing trash, staff wearing hairnets and gloves, and if there were dirty dishes sitting around the kitchen. -He knew the double door freezer had an issue and there was work done on the freezer by maintenance staff but he did not recall when the work was completed. -The freezer was an ongoing issue. -He expected the freezer to be cleaned and defrosted once a week. -He did not know the oven and knobs were not cleaned. -He expected dietary staff to clean the oven weekly and the knobs to be removed from the stove to clean thoroughly. -He did not know the shelves in the three refrigerators were rusted, and he would inquire about any surplus parts available to replace them. -He did not know there were foods not dated but staff jumped in to cook breakfast while the DM was out due to illness. -He expected staff to date any opened food items. -He did not know the microwave was rusted and the seal was deteriorating. -He last saw the inside of the microwave two months ago and did not notice any rust or the broken seal. -He expected the microwave to be cleaned by the dietary staff once a month. -The kitchen staff had cleaning products provided to them by a contracted company. <p>Interview with the maintenance staff 01/16/20 at 9:37 am revealed:</p> <ul style="list-style-type: none"> -He removed ice from the freezer a couple of 	D 282		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL031019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/16/2020
--	--	--	---

NAME OF PROVIDER OR SUPPLIER THE GARDENS OF ROSE HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 517 S SYCAMORE STREET, HWY 117 ROSE HILL, NC 28458
---	--

(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 282	Continued From page 6 times and the last time may have been Monday, 01/13/20. -The freezer had new gaskets placed along the doors after the last environmental health report, in January 2020. -He thought the condensation around the freezer doors may be caused by the temperature setting being too low.	D 282		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to administer medications as ordered to 1 of 5 sampled residents (#2) which included medications used to treat fungal infections, iron deficiency,	D 344	D 344 Facility obtained medication order clarification from prescribing practitioner In-service with facility Resident Care Director and facility medication administration technicians. Topics included; -medication orders -admission or readmission order process -medication orders verification process -medication administration -topical medication administration -medication storage and disposal -self administration order process Weekly - Ongoing The Resident Care Director shall conduct weekly, unannounced medication administration observations to ensure compliance.	1/15/20 1/17/20 1/17/20

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL031019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/16/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE GARDENS OF ROSE HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 517 S SYCAMORE STREET, HWY 117 ROSE HILL, NC 28458
---	--

(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 344	<p>Continued From page 8</p> <p>12/11/19 for first shift (7:00 am to 3:00 pm). -There was documentation that Resident #2 was hospitalized from 12/12/19 to 12/23/19. -There was documentation that ketoconazole shampoo was discontinued on 12/24/19.</p> <p>Review of Resident #2's January 2020 eMAR revealed there was no entry for ketoconazole shampoo.</p> <p>Observation of Resident #2's medication on hand on 01/15/20 at 11:45 am revealed there was one opened bottle of ketoconazole available for use dispensed on 11/21/19 with approximately three-fourths of the contents remaining.</p> <p>Interview with Resident #2 on 01/16/20 at 10:00 am revealed: -She had her hair shampooed by staff and by the beauty shop. -She did not recall the date staff last used the shampoo the doctor ordered, but her scalp was better. -She no longer had sores on her scalp.</p> <p>Telephone interview with a representative from the facility contracted pharmacy on 01/16/20 at 8:09 am revealed: -There was one bottle of ketoconazole dispensed on 11/21/19 and the order was active in the computer system. -There were no discontinue orders in the computer system. -The ketoconazole was not listed on the 12/23/19 FL-2 and a clarification request was sent to the facility to have the physician complete. -The physician signed the clarification order on 01/03/20 and the ketoconazole was continued. -The 01/03/20 order was treated as a continuation and new order date.</p>	D 344		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL031019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/16/2020
--	--	--	---

NAME OF PROVIDER OR SUPPLIER THE GARDENS OF ROSE HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 517 S SYCAMORE STREET, HWY 117 ROSE HILL, NC 28458
---	--

(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 344	<p>Continued From page 9</p> <ul style="list-style-type: none"> -There were no other dispense dates for ketoconazole because the facility had to request refills for this item. -There were no refill request for Resident #2's ketoconazole. <p>Interview with a day shift medication aide (MA) on 01/16/20 at 12:06 pm revealed:</p> <ul style="list-style-type: none"> -She was not always assigned to the 200 hall medication cart and started administering medications on the 200 hallway on 01/13/20. -She had not used ketoconazole shampoo for Resident #2 during the week. <p>Interview with Resident #2's physician on 01/15/20 at 4:35 pm revealed:</p> <ul style="list-style-type: none"> -In the past, Resident #2 had complaints of lesions like "cradle cap" on her scalp. -She ordered ketoconazole for Resident #2 to use during her showers. -Resident #2's scalp had improved. <p>Refer to interview with a first shift medication aide (MA) on 01/15/20 at 3:07 pm.</p> <p>Refer to interview with the Resident Care Director (RCD) on 01/15/20 at 3:07 pm.</p> <p>Refer to Interview with the Administrator on 01/15/20 at 4:48 pm.</p> <p>2. Review of Resident #2's omission order clarification dated 01/02/20 revealed there was an order for Jublia (used to treat nail fungus) treat apply to fingernails for twelve weeks and signed by the physician on 01/03/20.</p> <p>Review of Resident #2's November and December 2019, and January 2020 electronic medication administration records (eMARs)</p>	D 344		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL031019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/16/2020
--	--	--	---

NAME OF PROVIDER OR SUPPLIER THE GARDENS OF ROSE HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 517 S SYCAMORE STREET, HWY 117 ROSE HILL, NC 28458
---	--

(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 344	<p>Continued From page 10</p> <p>revealed there were no entries for Jublia.</p> <p>Observation of Resident #2's medication on hand on 01/16/20 at 12:04 pm revealed there was one opened 4 milliliter bottle of Jublia dispensed on 11/27/19 and there was approximately one-third remaining in the bottle.</p> <p>Interview with Resident #2 on 01/16/20 at 10:00 am revealed: -Staff put a cream on the two fingernails on her left hand. -She did not recall the last time staff applied the cream but her nails were better now.</p> <p>Observation of Resident #2's fingernails on 01/16/20 at 10:00 am revealed: -Resident #2 had chipped pink fingernail polish on the fingernail on her left hand. -There was no visible fingernail fungus on the fingernails on her left hand.</p> <p>Telephone interview with a representative from the facility contracted pharmacy on 01/16/20 at 8:09 am revealed: -There was one bottle of Julia dispensed on 11/27/19. -Resident #2's Jublia order was set in the computer system to end on 02/2020 for a 12 week treatment time. -Jublia was an anti-fungal medication and the medication was not sent with the batch refill for the facility. -The facility had to request a refill of creams, ointments, and shampoos because there was no way to determine when the amount was used completely.</p> <p>Interview with a day shift medication aide (MA) on 01/16/20 at 12:06 pm revealed she knew</p>	D 344		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL031019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/16/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER
THE GARDENS OF ROSE HILL

STREET ADDRESS, CITY, STATE, ZIP CODE
**517 S SYCAMORE STREET, HWY 117
ROSE HILL, NC 28458**

(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 344	<p>Continued From page 11</p> <p>Resident #2 had Jublia available for administration but she had not placed it on her fingernails because she did not see it on the computer screen for Resident #2's eMAR.</p> <p>Telephone interview with Resident #2's physician on 01/15/20 at 4:35 pm revealed: -Resident #2 had complaints of having fingernail fungus and she ordered Jublia to treat the fungus. -She ordered Jublia for a 12 week treatment cycle and if Resident #2 had not received the medication as ordered she would need to extend the treatment time.</p> <p>Refer to interview with a first shift medication aide (MA) on 01/15/20 at 3:07 pm.</p> <p>Refer to interview with the Resident Care Director (RCD) on 01/15/20 at 3:07 pm.</p> <p>Refer to interview with the Administrator on 01/15/20 at 4:48 pm.</p> <p>3. Review of Resident #2's physician orders dated 07/05/19 revealed there was an order for ferrous sulfate 325 mg (used to treat low blood levels of iron) take one tablet twice daily.</p> <p>Review of Resident #2's omission order clarification dated 01/02/20 revealed there was an order for ferrous sulfate 325 mg twice daily and signed by the physician on 01/03/20.</p> <p>Review of Resident #2's November 2019 electronic medication administration record (eMAR) revealed: -There was an entry for ferrous sulfate 325 mg take one tablet twice daily, scheduled at 9:00 am and 8:00 pm. -There was documentation of administration from</p>	D 344		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL031019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/16/2020
--	--	--	---

NAME OF PROVIDER OR SUPPLIER THE GARDENS OF ROSE HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 517 S SYCAMORE STREET, HWY 117 ROSE HILL, NC 28458
---	--

(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 344	<p>Continued From page 12</p> <p>11/01/19 to 11/30/19 at 9:00 am and 8:00 pm.</p> <p>Review of Resident #2's December 2019 eMAR revealed:</p> <ul style="list-style-type: none"> -There was an entry for ferrous sulfate 325 mg take one tablet twice daily, scheduled at 9:00 am and 8:00 pm. -There was documentation of administration from 12/01/19 to 12/11/19 at 9:00 am and 8:00 pm. -There was documentation of administration on 12/12/19 at 9:00 am. -There was documentation that Resident #2 was hospitalized from 12/12/19 at 8:00 pm to 12/24/19 at 9:00 am. -There was documentation that ferrous sulfate was discontinued on 12/24/19. <p>Review of Resident #2's January 2020 eMAR revealed:</p> <ul style="list-style-type: none"> -There was an entry for ferrous sulfate 325 mg take one tablet twice daily. -There was no documentation of administration and there was documentation of ferrous sulfate being discontinued on 01/09/20. <p>Observation of Resident #2's medication on hand on 01/15/20 at 11:40 am revealed there were 14 ferrous sulfate tablets available for administration and 28 tablets that were dispensed on 12/26/19.</p> <p>Telephone interview with a representative from the facility contracted pharmacy on 01/16/20 at 8:09 am revealed:</p> <ul style="list-style-type: none"> -Resident #2's ferrous sulfate was dispensed with the batch refill on 12/19/19 for a 28 day supply. -Resident #2's ferrous sulfate was also set to dispense with the next batch refill on 01/23/20. -The order for Resident #2's ferrous sulfate was active in the computer system and there were no discontinue orders. 	D 344		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL031019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER THE GARDENS OF ROSE HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 517 S SYCAMORE STREET, HWY 117 ROSE HILL, NC 28458
--	--

(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 344	<p>Continued From page 13</p> <p>-Resident #2's ferrous sulfate was not listed on the 12/23/19 FL-2 and this medication was listed on the clarification order form.</p> <p>-Resident #2's ferrous sulfate was clarified on 01/03/20.</p> <p>Telephone interview with Resident #2's physician on 01/15/20 at 4:35 pm revealed:</p> <p>-Resident #2 had ferrous sulfate ordered because she was diagnosed with chronic anemia by her predecessor who ordered an iron study for Resident #2 to determine this diagnosis.</p> <p>-If Resident #2 had not received the ferrous sulfate as ordered her hemoglobin may drop a little bit.</p> <p>Review of Resident #2's laboratory results dated 01/02/20 revealed her red blood cell count was low, hemoglobin and hematocrit was normal.</p> <p>Refer to interview with a first shift medication aide (MA) on 01/15/20 at 3:07 pm.</p> <p>Refer to interview with the Resident Care Director (RCD) on 01/15/20 at 3:07 pm.</p> <p>Refer to interview with the Administrator on 01/15/20 at 4:48 pm.</p> <p>4. Review of Resident #2's omission order clarification dated 01/02/20 revealed there was an order for lansoprazole (used to decrease acid in the stomach) 30 mg every morning and signed by the physician on 01/03/20.</p> <p>Review of Resident #2's November 2019 electronic medication administration record (eMAR) revealed</p> <p>-There was an entry for lansoprazole 30 mg take one tablet daily, scheduled for 9:00 am.</p>	D 344		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL031019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/16/2020
--	--	--	---

NAME OF PROVIDER OR SUPPLIER THE GARDENS OF ROSE HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 517 S SYCAMORE STREET, HWY 117 ROSE HILL, NC 28458
---	--

(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 344	<p>Continued From page 14</p> <p>-There was documentation of administration from 11/01/19 to 11/30/19 at 9:00 am.</p> <p>Review of Resident #2's December 2019 eMAR revealed:</p> <p>-There was an entry for lansoprazole 30 mg take one tablet daily, scheduled at 9:00 am.</p> <p>-There was documentation of administration from 12/01/19 to 12/12/19 at 9:00 am.</p> <p>-There was documentation that Resident #2 was hospitalized from 12/12/19 at 9:00 am to 12/24/19 at 9:00 am.</p> <p>-There was documentation that lansoprazole was discontinued on 12/24/19.</p> <p>Review of Resident #2's January 2020 eMAR revealed:</p> <p>-There was an entry for lansoprazole 30 mg take one tablet daily, scheduled at 8:00 am.</p> <p>-There was no documentation of administration and there was documentation of discontinuation on 01/09/20.</p> <p>Observation of Resident #2's medication on hand on 01/15/20 at revealed there were 27 lansoprazole tablets available for administration and 28 tablets were dispensed on 12/26/19.</p> <p>Interview with Resident #2 on 01/16/20 at 10:00 am revealed she was not able to recall her pills but she did not have problems with her stomach.</p> <p>Telephone interview with a representative from the facility contracted pharmacy on 01/16/20 at 8:09 am revealed:</p> <p>-Resident #2 had taken lansoprazole for some time, and the most recent order date was 01/03/20.</p> <p>-Lansoprazole was dispensed on 12/19/19 for a 28 day supply.</p>	D 344		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL031019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/16/2020
--	--	--	---

NAME OF PROVIDER OR SUPPLIER THE GARDENS OF ROSE HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 517 S SYCAMORE STREET, HWY 117 ROSE HILL, NC 28458
---	--

(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 344	<p>Continued From page 15</p> <p>-Resident #2's lansoprazole was set to dispense again with the batch refill on 01/23/20.</p> <p>Interview with a day shift medication aide (MA) on 01/16/20 at 12:06 pm revealed she recalled administering lansoprazole to Resident #2 that morning, (01/16/20) but not the day before.</p> <p>Telephone interview with Resident #2's physician on 01/15/20 at 4:40 pm revealed: -Lansoprazole was ordered for Resident #2 to treat gastro-esophageal reflux disease. -Resident #2 did not have an ulcer or gastro-intestinal bleed so she may only have some acid reflux if she did not receive lansoprazole for 12 days.</p> <p>Refer to interview with a first shift medication aide (MA) on 01/15/20 at 3:07 pm.</p> <p>Refer to interview with the Resident Care Director (RCD) on 01/15/20 at 3:07 pm.</p> <p>Refer to interview with the Administrator on 01/15/20 at 4:48 pm.</p> <p>5. Review of Resident #2's physician orders dated 10/15/18 revealed there was an order for cetirizine 10 mg at bedtime.</p> <p>Review of Resident #2's omission order clarification dated 01/02/20 revealed there was an order for cetirizine (used to treat seasonal allergies) 10 mg at bedtime and signed by the physician on 01/03/20.</p> <p>Review of Resident #2's November 2019 electronic medication administration record (eMAR) revealed -There was an entry for cetirizine 10 mg take one</p>	D 344		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL031019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/16/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER THE GARDENS OF ROSE HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 517 S SYCAMORE STREET, HWY 117 ROSE HILL, NC 28458
--	--

(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 344	<p>Continued From page 16</p> <p>tablet at bedtime, scheduled for 8:00 pm. -There was documentation of administration from 11/01/19 to 11/30/19 at 8:00 pm.</p> <p>Review of Resident #2's December 2019 eMAR revealed: -There was an entry for cetirizine 10 mg take one tablet at bedtime, scheduled for 8:00 pm. -There was documentation of administration from 12/01/19 to 12/11/19 at 8:00 pm. -There was documentation that Resident #2 was at the hospital from 12/12/19 to 12/23/19. -There was documentation that cetirizine was discontinued on 12/24/19.</p> <p>Review of Resident #2's January 2020 eMAR revealed there was no entry for cetirizine.</p> <p>Observation of Resident #2's medication on hand on 01/15/20 at 11:40 am revealed there were 18 cetirizine tablets available for administration and 28 tablets were dispensed on 12/26/19.</p> <p>Interview with Resident #2 on 01/16/20 at 10:00 am revealed she did not recall the name of her pills but she had a runny nose and needed facial tissues daily.</p> <p>Telephone interview with a representative from the facility's contracted pharmacy on 01/16/20 at 8:09 am revealed: -Resident #2's cetirizine had an original order date of 10/15/18. -The dispense date was 12/19/19 for a 28 day supply. -Resident #2's cetirizine was set to dispense again with the facility's batch refill on 01/23/20.</p> <p>Interview with Resident #2's physician on 01/15/20 at 4:40 pm revealed:</p>	D 344		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL031019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/16/2020
--	--	--	---

NAME OF PROVIDER OR SUPPLIER THE GARDENS OF ROSE HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 517 S SYCAMORE STREET, HWY 117 ROSE HILL, NC 28458
---	--

(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 344	<p>Continued From page 17</p> <ul style="list-style-type: none"> -Cetirizine was ordered for Resident #2 because she had complaints of allergies. -Resident #2 used cetirizine for symptomatic control of seasonal allergies. -If Resident #2 did not receive cetirizine as ordered she may have an increase of allergy symptoms, such as a runny nose, stuffy nose. <p>Refer to interview with a first shift medication aide (MA) on 01/15/20 at 3:07 pm.</p> <p>Refer to interview with the Resident Care Director (RCD) on 01/15/20 at 3:07 pm.</p> <p>Refer to interview with the Administrator on 01/15/20 at 4:48 pm.</p> <p>6. Review of Resident #2's omission order clarification dated 01/02/20 revealed there was an order for furosemide (used to treat fluid retention and shortness of breath) 20 mg half tablet daily and signed by the physician on 01/03/20.</p> <p>Review of Resident #2's previous physician orders revealed there was an order dated 11/06/19 to discontinue current furosemide orders and start furosemide 20 mg take half tablet (10 mg) daily.</p> <p>Review of Resident #2's November 2019 electronic medication administration record (eMAR) revealed</p> <ul style="list-style-type: none"> -There was an entry for furosemide 20 mg take one tablet daily. -There was documentation of administration from 11/01/19 to 11/06/19 at 9:00 am. -There was another entry for furosemide 20 mg take half tablet (10 mg) daily, scheduled at 9:00 am. -There was documentation of administration of 	D 344		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL031019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/16/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER THE GARDENS OF ROSE HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 517 S SYCAMORE STREET, HWY 117 ROSE HILL, NC 28458
--	--

(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 344	<p>Continued From page 18</p> <p>the half tablet from 11/08/19 to 11/30/19 at 9:00 am.</p> <p>Review of Resident #2's December 2019 eMAR revealed:</p> <ul style="list-style-type: none"> -There was an entry for furosemide 20 mg take a half tablet (10 mg) daily, scheduled at 9:00 am. -There was documentation of administration from 12/01/19 to 12/12/19 at 9:00 am/ -There was documentation that Resident #2 was at the hospital from 12/12/19 to 12/23/19. -There was documentation that furosemide was discontinued on 12/24/19. <p>Review of Resident #2's January 2020 eMAR revealed:</p> <ul style="list-style-type: none"> -There was an entry for furosemide 20 mg take a half tablet (10 mg) daily, scheduled at 8:00 am. -There was no documentation of administration and there was documentation of furosemide being discontinued on 01/09/20. <p>Observation of Resident #2's medication on hand on 01/15/20 at revealed there were 22 half tablets of furosemide available for administration and 28 tablets were dispensed on 12/26/19.</p> <p>Telephone interview with a representative from the facility's contracted pharmacy on 01/16/20 at 8:09 am revealed:</p> <ul style="list-style-type: none"> -There was an active order for furosemide 20 mg a half a tablet, 10 mg, and the most recent order date was 01/03/20. -There were no discontinue orders for furosemide in the computer system. -There were 14 tablets of furosemide dispensed on 12/19/19 and the tablets were cut in half for 28 halves. <p>Interview with a first shift medication aide (MA) on</p>	D 344		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL031019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/16/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER THE GARDENS OF ROSE HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 517 S SYCAMORE STREET, HWY 117 ROSE HILL, NC 28458
--	--

(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 344	<p>Continued From page 19</p> <p>01/16/20 at 12:06 pm revealed she administered furosemide a half tablet to Resident #2 that morning (01/16/20), but she did not recall administering it prior to that day.</p> <p>Telephone interview with Resident #2's physician on 01/15/20 at 4:34 pm revealed:</p> <ul style="list-style-type: none"> -Resident #2 did not have congestive heart failure but she did have some peripheral edema. -In the past Resident #2 had shortness of breath and she was placed on furosemide 20 mg daily. -Once Resident #2's shortness of breath improved the furosemide was decreased to 10 mg daily. -If Resident #2 did not received furosemide as ordered she might have increased peripheral edema. -She had seen her since her return from the hospital and she had not had any complaints of shortness of breath or peripheral edema. <p>Refer to interview with a first shift medication aide (MA) on 01/15/20 at 3:07 pm.</p> <p>Refer to interview with the Resident Care Director (RCD) on 01/15/20 at 3:07 pm.</p> <p>Refer to interview with the Administrator on 01/15/20 at 4:48 pm.</p> <p>Interview with a first shift medication aide (MA) on 01/15/20 at 3:07 pm revealed:</p> <ul style="list-style-type: none"> -The process for residents' FL-2s and medication orders was to fax the documents to the pharmacy and place the originals into a folder for the Resident Care Director (RCD) to review. -The pharmacy placed the medication order into the electronic medication administration record (eMAR). -The medication appeared on the computer 	D 344		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL031019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER THE GARDENS OF ROSE HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 517 S SYCAMORE STREET, HWY 117 ROSE HILL, NC 28458
--	--

(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 344	<p>Continued From page 20</p> <p>screen once the pharmacy placed it into the computer system and it was approved by the RCD.</p> <ul style="list-style-type: none"> -The MAs did cart audits weekly and had to turn in a form to the RCD by Friday of every week documenting the cart audit. -Cart audits were done by printing off the current months eMARs and comparing them to the medication available on the cart. -The MAs were assigned specific resident rooms by the Administrator. -If there were medications on the cart for a resident that was not listed on the eMAR, the MAs was supposed to remove it or contact the pharmacy to ensure it should be removed. -The RCD reviewed the cart audit forms. <p>Interview with the RCD on 01/15/20 at 3:30 pm revealed:</p> <ul style="list-style-type: none"> -She received resident FL-2s and medication orders from providers and the MAs. -She compared the FL-2s with medications the resident was previously on if the FL-2 was generated due to a hospitalization. -If there were medication missing on the hospital FL-2, a medication reconciliation form was completed and she faxed it to the resident's physician. -If the physician was due to come, because the physician came on Thursdays, she did not fax the medication reconciliation form but waited until the physician arrived at the facility to show to her. -She and the MAs faxed FL-2s and medication reconciliation forms to the pharmacy and the pharmacy placed the orders into the computer system. -When the medication order was placed into the computer system, she had to verify the medication order in the computer system before the MAs were able to administer the medication. 	D 344		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL031019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/16/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER THE GARDENS OF ROSE HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 517 S SYCAMORE STREET, HWY 117 ROSE HILL, NC 28458
--	--

(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 344	<p>Continued From page 21</p> <ul style="list-style-type: none"> -She was not able to complete an eMAR review but the MAs did cart audits weekly and documented on a form any discrepancies found during the cart audit. -She reviewed the forms for the cart audits. -Resident #2 was hospitalized in December 2019 and there was a new FL-2 completed for Resident #2. -There were medications Resident #2 had prescribed prior to the hospitalization that were not on the FL-2. -The pharmacy sent over a medication order clarification form for Resident #2 on 12/30/19 with medications that needed clarification and she faxed it to the physician for review and signature. -After the physician reviewed and signed Resident #2's medication order clarification form, she faxed it to the pharmacy on 01/03/20. -She did not know six of Resident #2's medications were not administered after the medication clarification orders were completed. -She accepted all the responsibility for Resident #2 not receiving the six medications after the orders were clarified. <p>Interview with the Administrator on 01/15/20 at 4:48 pm revealed:</p> <ul style="list-style-type: none"> -The RCD was responsible for ensuring all medication orders were accurate in the eMAR system. -The MAs were supposed to do cart audits weekly and give the audit results to the RCD for her to review. -He did not know Resident #2 missed doses of six medication from 01/03/20 to 01/15/20. -The RCD was primarily responsible for clinical issues within the facility and he primarily managed the building issue such as repairs, maintenance, food service, supply or equipment requests. 	D 344		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL031019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/16/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER THE GARDENS OF ROSE HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 517 S SYCAMORE STREET, HWY 117 ROSE HILL, NC 28458
--	--

(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 344	Continued From page 22 -If the RCD was not able to resolve a clinical issue then he would intervene. -The facility's policy was if an FL-2 was 24 hours from the readmit date a medication reconciliation was generated. -In this case, the pharmacy generated a medication reconciliation form. -He did not know why the medications were all discontinued on 01/09/20.	D 344		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to observe 1 of 1 resident (#3) apply a steroid cream by leaving the cream in the resident's room. The findings are: Review of Resident #3's current FL-2 dated 06/25/19 revealed: -Diagnoses included sepsis due to streptococcus.	D 366	D 366 Facility staff removed and discarded topical cream from resident's room. Medication Administration In-Service with Resident Care Director and facility medication administration technicians. Topics included; -medication administration -topical medication administration -medication storage and disposal -self-administration order process Weekly-Ongoing Resident Care Director shall conduct weekly, unannounced medication administration observations to ensure compliance.	1/14/20 1/17/20 1/17/20

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL031019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/16/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER THE GARDENS OF ROSE HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 517 S SYCAMORE STREET, HWY 117 ROSE HILL, NC 28458
--	--

(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 366	<p>Continued From page 23</p> <p>pneumonia, moderate protein calorie malnutrition, unspecified dementia without behavioral disturbance, essential (primary) hypertension (HTN) difficulty in walking, other lack of coordination, altered in mental status, continue commination deficient, history of falling and urinary tract infection (UTI), and acute kidney failure.</p> <p>-There were no physician orders to self-administer medications.</p> <p>Review of Resident #3's physician order dated 07/02/19 revealed an order for Triamcinolone Acetonide 0.1% Cream to be applied twice daily to trunk, arms and legs. (Triamcinolone Acetonide is a synthetic corticosteroid that is used topically to treat various skin conditions).</p> <p>Observation on 01/14/20 at 11:00 am in Resident #3's bathroom revealed:</p> <p>-A medication cup with Resident #3's name was sitting on the top of the dresser in Resident #3's bathroom.</p> <p>-The medication cup contained 5 milliliter (ml) of a white cream.</p> <p>Interview with Resident #3 on 11/14/20 at 11:30 am revealed:</p> <p>-She did not have an order to self-administer her medications.</p> <p>-She had no idea about the cream that was left in her bathroom on the top of her dresser.</p> <p>-The cream had been there for about 6 months.</p> <p>-She did not remember the last time that she used the cream.</p> <p>-The medication aide (MA) usually applied the cream on her body twice daily.</p> <p>Review of Resident #3's electronic Medication Administration Record (e-MAR) for December</p>	D 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL031019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/16/2020
--	--	--	---

NAME OF PROVIDER OR SUPPLIER THE GARDENS OF ROSE HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 517 S SYCAMORE STREET, HWY 117 ROSE HILL, NC 28458
---	--

(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 366	<p>Continued From page 24</p> <p>2019 revealed:</p> <ul style="list-style-type: none"> -There was a computer-generated entry for Triamcinolone Acetonide cream 0.1% apply to trunk, arms and legs twice daily. -The Triamcinolone Acetonide cream 0.1% had been signed off by a medication aide (MA) on 01/14/20 at 8:00 am. <p>Observation of the medication cart on 01/14/20 at 11:30 am revealed Triamcinolone Acetonide cream 0.1% was on the medication cart.</p> <p>Interview with a MA who signed the e-MAR on 01/14/20 at 11:30 am revealed:</p> <ul style="list-style-type: none"> -She did not know a medication cup with a cream was left in Resident #3's bathroom. -Resident #3 did not have an order to self-administer her medications. -She applied Triamcinolone Acetonide to the resident's affected areas on 01/14/20 at 8:00 am. -She had never left medication treatments in Resident #3's room. -The writing on the medication cup which contained the cream was not her hand writing. <p>Interview with a second MA on 01/15/20 at 4:00 pm revealed:</p> <ul style="list-style-type: none"> -Resident #3 did not have an order to self-administer her medications. -Resident #3 normally wanted to apply the cream to the affected areas herself. -The resident was very private and did not like for staff to see her naked. -The MA had left Triamcinolone Acetonide cream in the resident's room, but she did not recall the last time. -The writing on the medication cup which contained the cream was not her hand writing. <p>Interview with the Resident Care Director (RCD)</p>	D 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL031019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/16/2020
--	--	--	---

NAME OF PROVIDER OR SUPPLIER THE GARDENS OF ROSE HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 617 S SYCAMORE STREET, HWY 117 ROSE HILL, NC 28458
---	--

(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 366	<p>Continued From page 25</p> <p>on 01/16/20 at 9:50 am revealed:</p> <ul style="list-style-type: none"> -Resident #3 did not have an order to self-administer her medications. -She did not know a MA had left Triamcinolone Acetonide 0.1% Cream in a medication cup in a resident's bathroom. -The MA should have applied the cream to the resident's affected areas and return the cream to the medication cart. -She would remind the MAs to apply cream to the resident's affected areas and return the medication treatment to the medication cart. <p>Interview with the Executive Director (ED)/Administrator on 01/16/20 at 11:09 am revealed:</p> <ul style="list-style-type: none"> -Resident #3 did not have an order to self-administer her medications. -He did not know a MA had left Triamcinolone Acetonide 0.1% Cream in a medication cup in Resident #3's bathroom. -The MA should have applied the cream to Resident #3's affected area. -The medication cup with cream should not have been left in the resident's room. <p>Review of the facility's topical medication administration policy (no date) revealed the topical medication should be applied to the resident's affected area, and the topical treatment should be stored in a medication container per agency policy.</p>	D 366		