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 _____ | R-C 01/09/2020 |

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

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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section and the Moore County Department of Social Services conducted an annual and follow-up survey and complaint investigation on 01/07/20-01/09/20. | D 000 | | |
| D 131 | 10A NCAC 13F .0406(a) Test For Tuberculosis<br><br>10A NCAC 13F .0406 Test For Tuberculosis<br>(a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to ensure 1 of 6 sampled staff (Staff C) was tested for the tuberculosis (TB) disease with a TB skin test upon hire in compliance with control measures adopted by the Commission for Public Health.<br><br>The findings are:<br><br>Review of Staff C's personnel record revealed:<br>-He was hired on 10/28/19 as a personal care aide (PCA) and was training to be a medication aide (MA).<br>-There was no documentation a TB skin test was completed after Staff C was hired.<br>-There was documentation of a TB skin test completed on 09/26/19 at a previous employer but the results were not interpreted and | D 131 | Human Resource Manager will ensure that staff members receive a two-step TB test.<br><br>Human Resource manager and ED will review personnel records at hire and monthly effective 1/20/20. | |



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Debbie Oliver — Executive Director — 02/20/20



Reviewed and Accepted by CD on 03/06/20

Revised 3/4/20
DO

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| D 131 | Continued From page 1<br>documented by a nurse.<br><br>Interview with Staff C on 01/09/20 at 1:20pm revealed:<br>-He currently worked as a MA and had started administering medications about 2 weeks ago.<br>-He had recently received a TB skin test at a previous employer but was not able to get the documentation.<br>-He had not received a TB skin test at the facility.<br><br>Telephone interview with the Special Care Unit (SCU) Coordinator on 01/09/20 at 1:45pm revealed:<br>-She had previously worked with Staff C at another facility.<br>-She was responsible for documenting the results of the staff TB skin test at the previous facility.<br>-She had documented the results of Staff C's TB skin test on 09/26/19 at the previous facility.<br>-She was not a nurse and did not know she was not supposed to document the results of a TB skin test.<br><br>Interview with the Business Office Manager (BOM) on 01/09/20 at 4:57pm revealed:<br>-She was responsible for ensuring staff had a TB skin test upon hire.<br>-She did not realize Staff C's TB test skin test was not valid because a nurse had not documented the results.<br>-She did not know a nurse needed to administer and read the TB skin test.<br><br>Interview with the Administrator on 01/09/20 at 5:05pm revealed:<br>-She did not know Staff C did not have a TB skin test when he was hired at the facility.<br>-The BOM was responsible for making sure all new employees were administered a TB skin test | D 131 | | |

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| D 131 | Continued From page 2<br>when hired.<br>-The BOM had received a TB skin test completed on 09/26/19 from Staff C's previous employer and thought that would count as the TB skin test needed upon hire.<br>-The BOM did not know the TB skin test from 09/26/19 was not read and the results documented by a nurse. | D 131 | | |
| D 234 | 10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio<br><br>10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations<br>(a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to ensure 1 of 7 sampled residents (Resident #5) had completed tuberculosis (TB) testing upon admission in compliance with the control measures for the Commission for Health Services.<br><br>The findings are:<br><br>Review of Resident #5's current FL2 dated 11/06/19 revealed diagnoses included dementia | D 234 | Care Coordinator will ensure that each resident receive a two-step TB test.<br><br>ED will ensure that each resident has a TB test before moving in.<br><br>Care Coordinator will ensure that the 2nd step is completed after the resident moves in.<br><br>Monthly audits will be performed by Care Coordinator effective 1/20/20. | |

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| D 234 | Continued From page 3<br>with behavior disturbance, hypertension, and type 2 diabetes.<br><br>Review of Resident #5's Resident Register revealed:<br>-The resident was admitted to the facility on 11/01/16.<br>-The resident was admitted from a skilled nursing rehabilitation center.<br><br>Review of Resident #5's Record revealed:<br>-There was documentation of a TB skin test documented on the electronic Medication Administration Record (eMAR) of the skilled nursing facility.<br>-The TB skin test was placed on 09/22/16 and read as negative on 09/25/16.<br>-The TB skin test did not include the nurse signature, lot number, site, or expiration date.<br>-There was documentation of a 2nd step TB skin test placed on 12/20/16 and read as negative on 12/20/16.<br>-There was no other documentation of a TB skin test for Resident #5.<br><br>Interview with the Administrator on 01/09/20 at 9:40am revealed:<br>-She thought she could accept the TB skin test completed on the eMAR from the skilled nursing facility for Resident #5.<br>-She did not realize the nurse signature was missing from the TB skin test completed on 09/22/16.<br>-She felt the nurse documented the wrong date on the TB test completed 12/20/16, however she could not remember when it was read.<br>-The previous marketing director and Special Care Unit (SCU) Coordinator would have been responsible for ensuring an accurate TB skin test was completed for Resident #5, however they | D 234 | | |

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| D 234 | Continued From page 4<br>were no longer employed at the facility.<br><br>Attempted interview with Resident #5's Responsible Party on 01/09/20 at 1:10pm was unsuccessful.<br><br>Based on observations, interview and record review, it was determined Resident #5 was uninterviewable. | D 234 | | |
| D 276 | 10A NCAC 13F .0902(c)(3-4) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(c) The facility shall assure documentation of the following in the resident's record:<br>(3) written procedures, treatments or orders from a physician or other licensed health professional; and<br>(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to ensure physician's orders were implemented for 1 of 7 sampled residents (Resident #1) related to care for a skin tear.<br><br>The findings are:<br><br>Review of Resident #1's current FL-2 dated | D 276 | Magnolia Gardens will ensure all Health Care is followed. The Care Coordinators will review all orders and ensure that the orders are on the EMAR.<br><br>Documentation training was completed on all direct care staff on 1/22/20 hosted by a RN.<br><br>Weekly monitoring will be completed by Care Coordinators effective 1/22/20. | |

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| D 276 | Continued From page 5<br>05/20/19 revealed diagnoses included Lewy body dementia and neurocognitive disorder.<br><br>Review of Resident #1's standing physician's orders for minor skin tears dated 07/30/19 revealed:<br>-The area of the skin tear should be cleaned with soap and water.<br>-Antibiotic ointment should be applied.<br>-The skin tear should be covered with gauze or a band aid.<br>-The dressing should be changed "every day and as needed until healed."<br>-If redness, swelling, drainage, or pain developed, the physician should be notified.<br><br>Review of Resident #1's incident report dated 09/15/19 at 12:45pm revealed:<br>-Resident #1 was found to have a skin tear on her left forearm.<br>-"Staff members were aware of it but did not know how the resident received it."<br>-Resident #1's PCP (primary care provider) was notified on 09/16/19 at 12:35pm during a physician's office visit.<br><br>Review of Resident #1's PCP's visit note dated 09/16/19 revealed:<br>-Resident #1 was treated for a skin tear to the left arm.<br>-The wound was cleaned, Bacitracin was applied (an antibiotic ointment), Vaseline and a nonstick dressing were applied by nursing staff to stay on for 72 hours.<br>-No antibiotics were warranted.<br><br>Review of Resident #1's physician's orders dated 09/18/19 revealed:<br>-The order was faxed to the facility on 09/18/19 at 5:58pm. | D 276 | | |

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| D 276 | Continued From page 6<br>-"Wound care to the left arm skin tear was to be done on 09/19/19 and continue wound care PRN (when necessary) after this date."<br><br>Review of Resident #1's September 2019 electronic Medication Administration Record (eMAR) revealed:<br>-There was an entry for "left arm skin tear wound care to be done as needed" with a start date of 09/19/19 and a stop date of 10/04/19.<br>-There was no documentation wound care had been administered from 09/19/19-09/30/19.<br><br>Review of Resident #1's October 2019 eMAR revealed:<br>-There was an entry for "left arm skin tear wound care to be done as needed" with a start date of 09/19/19 and a stop date of 10/04/19.<br>-There was no documentation wound care had been administered from 10/01/19-10/04/19.<br><br>Review of Resident #1's nursing notes revealed:<br>-On 09/19/19 there was a late entry documenting "new order for left arm skin tear, wound to be done as needed."<br>-On 09/24/19, there was documentation "resident wound was cleaned and rewrapped by RCC (Resident Care Coordinator)."<br><br>Interview with a medication aide (MA) on 01/08/20 at 4:15pm revealed:<br>-She was the MA who completed Resident #1's incident report on 09/15/19.<br>-Resident #1 reported the skin tear to her on 09/15/19.<br>-She cleaned the skin tear with wound cleanser and wrapped it with an elastic bandage.<br>-She did not follow the physician's standing orders and apply gauze or antibiotic ointment to the skin tear because she wanted the physician | D 276 | | |

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| D 276 | Continued From page 7<br>to look at it first since the skin tear was "large."<br>-She did not notify Resident #1's PCP of the skin tear or request further wound care instructions, and she could not say why she did not.<br>-Resident #1's responsible party (RP) took Resident #1 to see her PCP the following day on 09/16/19.<br>-She thought after Resident #1's PCP visit, she had orders to clean the wound, apply antibiotic cream, new gauze, and an elastic bandage to the wound every shift.<br>-If wound care had been administered to Resident #1, it wound be documented in Resident #1's nurses notes.<br><br>Telephone interview with the Special Care Unit (SCU) Coordinator on 01/09/20 at 1:21pm revealed:<br>-If a resident had a skin tear, the MA should follow the physician's standing orders and clean the wound, apply antibiotic cream, and gauze.<br>-The MA should immediately notify the PCP and the RP.<br>-She was not aware of Resident #1's skin tear until she arrived to work on 09/16/19 and Resident #1's RP reported it to her.<br>-The MA had not notified the PCP or the RP, and she did not know why.<br>-The RP took Resident #1 to visit her PCP on 09/16/19.<br>-The skin tear was dressed at the PCP's office.<br>-Resident #1 did not return to the facility with any new written orders, but Resident #1's RP had reported to the RCC, the PCP wanted wound care to be administered daily.<br>-She faxed an order request to Resident #1's PCP on 09/18/19 and received written orders to "provide wound care to the left arm skin tear on 09/19/19 and PRN after that date."<br>-She thought "PRN" wound care meant to change | D 276 | | |

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| D 276 | Continued From page 8<br>the dressing if any drainage or blood was observed on the bandage or if the bandage was wet from taking a shower.<br>-She did not instruct her staff to continue to follow the physician's standing orders for daily dressing changes, and she did not request clarification for the "PRN" wound care instructions.<br>-If wound care was administered, it should be documented on both Resident #1's eMAR and her nursing notes.<br><br>Interview with the Administrator on 01/09/20 at 4:57pm revealed:<br>-She would have expected the RCC to obtain clarification of "PRN" wound care orders received for Resident #1.<br>-She would have expected staff to follow the physician's standing orders for skin tears until clarification could be obtained regarding Resident #1's skin tear.<br><br>Attempted telephone interview with Resident #1's PCP on 01/09/20 at 2:12pm was unsuccessful. | D 276 | | |
| D 338 | 10A NCAC 13F .0909 Resident Rights<br><br>10A NCAC 13F .0909 Resident Rights<br>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.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to assure residents were treated with respect and dignity related to denying a resident of cigarettes (Resident #5) and speaking and treating residents in a rude and disrespectful manner. | D 338 | | |

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| D 338 | Continued From page 9<br><br>1. Review of Resident #5's current FL2 dated 11/27/19 revealed diagnoses included dementia with behavior disturbance, hypertension, and type 2 diabetes.<br><br>Review of Resident #5's progress notes revealed:<br>-On 08/30/19 (no time), the resident smoked after breakfast, but was "not allowed to smoke anymore today because of disrespect".<br>-Another entry on 08/30/19 (no time), the resident "got mad because he could not smoke, he was told because of disrespect earlier, he told me he would throw me in the medicine cart".<br>-On 10/08/19 (no time), "the resident does nothing, but sleep have attitudes, and ask for cigarettes every 20 minutes, very nerve wrecking".<br>-On 10/09/19 (no time), "the resident don't do nothing [sic] but eat, sleep, and beg for cigarettes and get mad when you tell him it's not time, he cuss the staff out and we are tired of it".<br>-On 10/15/19 (no time), "the resident went back to sleep to wake up and worry everybody about cigarettes every 5 minutes".<br><br>Telephone interview with a personal care aide (PCA) on 01/09/20 at 1:18pm revealed:<br>-She documented resident's behavior on 10/08/19, 10/09/19, and 10/15/19.<br>-She did not mean that the resident was "nerve wrecking", she documented the comments because her feelings were hurt.<br>-She did not mean she was tired of the resident, she documented incorrectly.<br>-She did not withhold Resident #5's cigarettes because of disrespect, the medication aide (MA) for that date held the cigarettes.<br>-She would always redirect the resident and tell him that it was not nice for him to speak rudely to | D 338 | All Magnolia Gardens staff will ensure all resident rights are met.<br><br>All staff will receive resident rights training at hire and annually, Human Resource Manager will monitor.<br><br>Regional LTC Ombudsman, completed a resident rights training for all staff on 1/29/20.<br><br>All staff also completed online CEU training on resident rights.<br><br>All direct Care Staff completed a documentation class on 1/22/20 hosted by a RN.<br><br>Monthly surveys will be issued to 5 residents or family members monthly. ED to review the results effective 1/31/20. | |

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| D 338 | Continued From page 10<br>staff.<br><br>Interview with a PCA on 01/09/20 at 5:17pm revealed:<br>-She documented the resident was refused cigarettes on 08/30/19 because of disrespect, however she did not refuse the resident cigarettes.<br>-The medication aides (MA) were responsible for providing the resident his cigarettes.<br>-She did not know it was against resident rights to hold the resident's cigarettes because of his behavior.<br>-She documented the resident's behavior because he was denied cigarettes.<br><br>Interview with the Special Care Unit (SCU) Coordinator on 01/09/20 at 1:57pm revealed:<br>-She heard about staff withholding cigarettes from Resident #5 because of "disrespect".<br>-She knew that staff withholding cigarettes from a resident for disrespect was against resident rights, "he has the right to smoke".<br>-She informed the staff that they could not withhold cigarettes.<br>-She reminded the resident of smoke times for the facility.<br>-Denying the resident his cigarettes would only "agitate him more".<br>-She and the Administrator had met with staff individually and removed some staff from the SCU.<br>-She had not personally completed any training with staff regarding resident rights and behavior.<br><br>Based on interview, observations, and record review, it was determined Resident #5 was not interviewable.<br><br>2. Interview with a resident on 01/08/20 at | D 338 | | |

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| D 338 | Continued From page 11<br><br>11:42am revealed:<br>-The resident was not able to hear well and one of the medication aides was "sarcastic" about her hearing impairment.<br>-The MA would speak loudly in front of everyone instead of coming close to speak directly to the resident.<br>-When it was time for medications, the medication aide "yells" that it's my turn to receive medications.<br>-The resident was embarrassed, and it hurt the resident's feelings when it occurred.<br><br>Interview with a second resident on 01/08/20 at 9:17am revealed:<br>-The resident observed staff being rude and disrespectful to residents.<br>-"The staff tried me and I said something back"<br>-A couple of weeks ago, in the evening, a resident fell and the staff "yelled, fussed and cursed at her, telling her she could get up on her own".<br>-"I don't say anything because I am afraid of retaliation".<br>-"Some residents were afraid to speak up out of fear of retaliation".<br>-"It makes me angry" to see staff being rude and unhelpful.<br>-The resident heard staff tell another resident, the other night, "you can get up on your own, every time I help you, it hurts my back".<br>-I don't think it's fair for staff to be rude.<br>-The resident had never told the Administrator of staff behavior, "I wasn't sure if she would believe me".<br><br>Interview with a third resident on 01/07/20 at 10:10am revealed:<br>-The staff in the evening all gathered together and did not work.<br>-The staff in the evening were rude to residents. | D 338 | | |

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| D 338 | Continued From page 12<br>-The younger personal care aides (PCAs) did not give showers as scheduled.<br>-After 8:00pm, none of the staff were around.<br>-There were enough staff, however they were unable to be found.<br>-When the staff were rude "it pisses me off".<br>-The resident spoke to the Administrator in the past and she informed her that she would "fix it", but nothing had been done.<br>-The Administrator was "hateful" to the resident at times, "it makes me upset".<br>- "I don't bother to say anything anymore".<br>-The resident had a staff member say "management will get rid of you, before they get rid of me" when she complained about the staff member in the past.<br>-"That mad me upset, I felt like I might need to find somewhere else to live".<br><br>Interview with a medication aide (MA) on 01/08/20 at 9:40am revealed:<br>-She works with residents who can be difficult.<br>-She had been instructed to have patience.<br>-She never observed staff treating residents rudely, and she had never been reprimanded for her behavior.<br>-She had some training in residents rights, "it's been a while".<br>-She remembered residents had the right to refuse.<br>-The resident rights were "somewhere in the employee handbook".<br><br>Interview with a first shift MA on 01/08/20 at 12:04pm revealed:<br>-She did not have any issues or problems with residents or their families.<br>-She had not observed any staff being rude to residents.<br>-She had not been reprimanded for her behavior | D 338 | | |

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| D 338 | Continued From page 13 | D 338 | | |

while employed at the facility.
-She had resident rights training when she started employment 3 years ago, she received no other training.
-Some resident had told her that they wait until in the morning to ask for help with some things, they will not ask evening shift staff.
-She did know why residents waited until morning shift.
-She had not heard anything bad about staff who work evening shift.

Interview with a medication aide (MA) on 01/08/20 at 11:49am revealed:
-She heard complaints from a resident "a couple of months ago" that staff on "B-Swing" (a team that enters mid-week to provide relief) were rude and refused care.
-She heard a staff member tell a resident that management would get rid of her (the resident) instead of staff after the resident notified management about the staff member's behavior.
-She informed the Administrator, who informed her, that she would address the issue and talk to staff.

Interview with an evening Supervisor/MA on 01/09/20 at 5:03pm revealed:
-She had some residents complain about how she spoke to them, however never had a verbal altercation with any resident.
-She gets any complaints worked out with residents.
-She never had to meet with the Administrator regarding her behavior with residents.
-She never yelled or felt that she disrespected the residents, "I just tell them the rules".
-She understood the residents had rights and received training upon hire.
-She had never been reprimanded or met with

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| D 338 | Continued From page 14<br>management about her behavior.<br><br>Interview with the Care Coordinator on 01/08/20 at 3:12pm revealed:<br>-She had a high expectation of staff and expected them to treat each resident with the highest respect.<br>-She thought all staff treated residents respectfully.<br>-She had received a complaint from a resident regarding a staff member's behavior and she spoke to them individually.<br>-The staff member got loud with her, however she was able to diffuse the situation.<br>-She expected staff to attend to the needs of the residents and treat residents with respect.<br>-She could not remember the last time she had to speak with a staff member due to a complaint.<br>-All staff received training on resident rights when they were first employed.<br>-There is no additional training after employment regarding resident rights.<br>-With the exception of lead MAs, there was no management in the building after 7:00pm to monitor staff.<br>-The Administrator recently spoke about rotating the managers every week to provide some oversight in the evenings.<br>-She and the Administrator would address staff individually with any complaints or concerns with behavior, however "that had not happened in a while".<br><br>Interview with the Special Care Unit (SCU) Coordinator on 01/09/20 at 1:57pm revealed:<br>-She had issues with staff having attitudes and speaking in a negative tone.<br>-She always reminded the staff to be mindful of the tone they used when speaking to residents.<br>-She received a couple of complaints from | D 338 | | |

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| D 338 | Continued From page 15<br>families regarding staff having attitudes.<br>-The attitudes and negative tone had been consistent since she had been employed at the facility.<br><br>Interview with the Administrator on 01/09/20 at 9:40am revealed:<br>-She only received one complaint "recently" from a resident about a staff member being rude.<br>-She spoke to the staff member and instructed her to not be so "boisterous" when speaking to residents.<br>-A resident did inform her that the evening shift staff were loud.<br>-She was able to observe both shifts as she stayed until about 8:30pm once per week and "it's quiet".<br>-She went around and asked residents regularly about any issues or concerns.<br>-She relied on her supervisors/MAs in the evenings to call and let her know of any issues.<br>-She thought most of the residents felt comfortable talking to her.<br>-She was not sure when the last resident rights training was completed, however it was discussed upon hire.<br>-She spoke to the staff on "B-crew" about being loud at night in the past.<br>-Residents were able to discuss any concerns in resident council meetings every week, and she heard no complaints about staff.<br>-She expected staff to not use profanity, not be rude, and not retaliate against anyone. | D 338 | | |
| D 358 | 10A NCAC 13F .1004(a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(a) An adult care home shall assure that the | D 358 | | |

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| D 358 | Continued From page 16<br>preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a physician for 1 of 7 residents (Resident #8) observed on the medication pass related to administering an as needed pain medication.<br><br>The findings are:<br><br>Review of Resident #8's current FL2 dated 05/20/19 revealed diagnoses included chronic pain, anxiety, osteoporosis, hypertension, and congestive heart failure.<br><br>Review of Resident #8's physician's visit summary dated 11/20/19 revealed a physician's order for Percocet (a controlled substance consisting of oxycodone and acetaminophen used to treat moderate to severe pain) 10mg/325mg take 1 tablet every 6 hours.<br><br>Review of Resident #8's physician's order revealed a physician's order dated 12/20/19 changing Percocet 10/325 to oxycodone 10mg (a controlled substance used to treat moderate to severe pain) take 1 tablet every 6 hours as needed for pain because the pharmacy did not have the Percocet tablets in stock.<br><br>Observation of medication pass on 01/07/20 at 12:13pm revealed the medication aide (MA) | D 358 | Med-Techs and Care Coordinators will ensure that all medication orders are followed.<br><br>All orders will be faxed to house pharmacy where a tech will enter the orders. Care Coordinators will review orders daily.<br><br>Care Coordinators will complete weekly med-pass audits to ensure the accuracy of MD orders effective 1/21/20. | |

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| D 358 | Continued From page 17<br>administered an oxycodone 10mg tablet to Resident #8 outside of the medication room without the resident asking for medication.<br><br>Review of Resident #8's December 2019 electronic Medication Administration Record (eMAR) revealed:<br>-There was a computer-generated entry for Percocet 10/325 take 1 tablet by mouth 4 times daily scheduled to administer at 8:00am, 12:00pm, 4:00pm, and 8:00pm.<br>-Percocet 10/325 was documented as administered 4 times daily at 8:00am, 12:00pm, 4:00pm, and 8:00pm from 12/01/19 to 12/31/19 except for 12/06/19, 12/10/19-12/11/19, 12/16/19-12/17/19, 12/22/19-12/24/19 when the resident was out of the facility.<br>-There was a computer-generated entry for oxycodone 10mg take 1 tablet every 6 hours as needed with a start date of 12/20/19.<br>-There was no documentation that oxycodone 10mg was administered from 12/20/19-12/31/19.<br><br>Review of Resident #8's January 2020 eMAR revealed:<br>-There was a computer-generated entry for Percocet 10/325 take 1 tablet by mouth 4 times daily scheduled to administer at 8:00am, 12:00pm, 4:00pm, and 8:00pm.<br>-Percocet 10/325 was documented as administered 4 times daily at 8:00am, 12:00pm, 4:00pm, and 8:00pm from 01/01/20-01/07/20 except for 01/05/20-01/06/20 when the resident was out of the facility.<br>-There was a computer-generated entry for oxycodone 10mg take 1 tablet every 6 hours as needed.<br>-There was no documentation that oxycodone 10mg was administered from 01/01/20-01/07/20. | D 358 | | |

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| D 358 | Continued From page 18<br><br>Review of Resident #8's December 2019 Control Substance Inventory Log for Percocet 10/325mg revealed the last tablet was administered on 12/20/19 at 8:00am.<br><br>Review of Resident #8's December 2019 and January 2020 Control Substance Inventory Log for oxycodone 10mg revealed:<br>-The first tablet of oxycodone 10mg was administered on 12/22/19 at 12:00pm.<br>-There was documentation of a total 71 tablets of oxycodone 10mg being administered to Resident #8.<br>-There were 4 tablets of oxycodone 10mg administered daily to Resident #8.<br><br>Observation of medications on hand for Resident #8 on 01/07/20 at 3:40pm revealed:<br>-There were 2 medication cards of oxycodone 10mg available to administer dispensed on 12/20/19.<br>-One medication card contained 30 tablets of oxycodone 10mg and the other medication card contained 19 tablets for a total number of tablets remaining of 49 tablets.<br>-There was no Percocet 10/325mg tablets available to administer.<br><br>Telephone interview with a pharmacist from Resident #8's pharmacy on 01/07/20 at 3:21pm revealed:<br>-The pharmacy dispensed 120 tablets of oxycodone 10mg with the directions to take 1 tablet every 6 hours as needed to Resident #8 on 12/20/19.<br>-The pharmacy last dispensed 120 tablets of Percocet 10/325 on 11/22/19.<br><br>Interview with Resident #8 on 01/09/20 at 10:45am revealed: | D 358 | | |

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| D 358 | Continued From page 19<br>-The doctor had changed her pain medication because the pharmacy could not get the Percocet.<br>-She did not know her pain medication was ordered as needed until recently.<br>-She has always taken her pain medication as scheduled.<br><br>Interview with a MA on 01/09/20 at 11:10am revealed:<br>-Resident #8 was administered the oxycodone 10mg on schedule daily at 8:00am, 12:00pm, 4:00pm, and 8:00pm.<br>-She did not know Resident #8's pain medication was changed from Percocet administered as scheduled to oxycodone as needed.<br>-She did not know the oxycodone 10mg order was listed on the eMAR.<br>-She was administering Resident #8's pain medication like she had always administered it.<br>-The MAs and the Resident Care Coordinator (RCC) were responsible for faxing new medication orders to the pharmacy.<br>-The RCC was responsible for approving all orders from the pharmacy to appear on the eMAR.<br>-The MAs were responsible for keeping a copy of each new medication in a physician's orders notebook in the medication room.<br>-The MAs were responsible for comparing each new medication to the order on the eMAR once the order was approved.<br>-The MAs were responsible for logging in the Nurse's notes every time a resident had a new medication order or a medication change.<br><br>Interview with the RCC on 01/09/20 at 12:56pm revealed:<br>-She did not know Resident #8's pain medication order had changed until 12/27/19 when she was | D 358 | | |

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| D 358 | Continued From page 20<br>administering medications.<br>-She found the order for the oxycodone 10mg in the medication room.<br>-She called Resident #8's Power of Attorney (POA) and found out the POA had delivered the oxycodone 10mg and a copy of the medication order to the facility on 12/20/19.<br>-The MA did not fax the medication order to the pharmacy when the POA gave her the order for the oxycodone.<br>-The oxycodone was available to administer and not the Percocet.<br>-She faxed the medication order to the facility's contracted pharmacy on 12/27/19 for the order to be added to the eMAR.<br>-She was responsible for faxing medication orders to the pharmacy and making sure the MAs received a copy for the physician's orders notebook and to file in each resident's chart.<br>-She was responsible for approving the medication orders to appear on the eMAR.<br>-The MAs were responsible for comparing the copy of the medication to the eMAR to make sure the order was entered correctly.<br>-MAs were responsible for removing all discontinued medications from the medication card and in the overflow.<br>-She was responsible for checking behind the MAs to make sure all discontinued medications were removed from the medication cart and returned to the pharmacy.<br><br>Telephone interview with Resident #8's POA on 01/08/29 at 4:00pm revealed:<br>-She delivered the oxycodone 10mg to the facility along with the medication order on 12/20/19.<br>-She handed the medication and order to the MA on duty.<br>-The pharmacy was not able to dispense the Percocet to Resident #8 because they did not | D 358 | | |

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| D 358 | Continued From page 21<br>have enough medication in stock.<br>-Resident #8 was about to run out of pain medication so she had picked the medication up at the pharmacy and delivered it to the facility.<br><br>Telephone interview with a nurse from Resident #8's primary care provider's office on 01/08/20 at 2:45pm revealed:<br>-Resident #8's Percocet 10/325 take 1 tablet 4 times daily was changed to oxycodone 10mg take 1 tablet every 6 hours as needed on 12/20/19.<br>-Resident #8 was responsible for asking for the oxycodone 10mg only when she needed and not on a scheduled basis.<br>-The facility staff should not be administering the oxycodone 10mg unless Resident #8 asked for the medication.<br><br>Interview with the Administrator on 01/09/20 at 11:40am revealed:<br>-She did not know Resident #8's oxycodone was being administered on a schedule when the order was written for as needed administration.<br>-The RCC or MAs were responsible for faxing new medication orders to the pharmacy and making a copy of each order for the new physician's orders notebook.<br>-The RCC and the MAs were responsible to obtain a copy of all medication orders.<br>-The pharmacy enters the medication order on the eMAR and the RCC was responsible for approving each new medication order for the medication to appear on the eMAR for the MAs.<br>-The MAs were responsible for checking the medication once it was delivered to the eMAR to make sure the label matched the eMAR.<br>-The MAs were responsible for administering medications based on the eMAR.<br>-The MAs were responsible for scanning each medication package to make sure they were | D 358 | | |

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| D 358 | Continued From page 22<br>dispensing the correct order to the correct patient. | D 358 | | |
| D 367 | 10A NCAC 13F .1004(j) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(j) The resident's medication administration record (MAR) shall be accurate and include the following:<br>(1) resident's name;<br>(2) name of the medication or treatment order;<br>(3) strength and dosage or quantity of medication administered;<br>(4) instructions for administering the medication or treatment;<br>(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;<br>(6) date and time of administration;<br>(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,<br>(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to ensure the electronic | D 367 | Human Resource Manager and Care Coordinator will ensure all med-techs have received proper training on the 8 steps of medication administration.<br><br>Care Coordinators will monitor staff weekly and RN will monitor staff monthly effective 1/21/20. | |

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| D 367 | Continued From page 23<br><br>Medication Administration Record (eMAR) was accurate for 1 of 7 residents observed on the medication pass (Resident #8) related to not removing a discontinued medication from the eMAR, documenting the administering of a medication but administering a different medication, and not documenting the effectiveness of an as needed medication.<br><br>The findings are:<br><br>Review of Resident #8's current FL2 dated 05/20/19 revealed diagnoses included chronic pain, anxiety, osteoporosis, hypertension, and congestive heart failure.<br><br>Review of Resident #8's physician's visit summary dated 11/20/19 revealed a physician's order for Percocet (a controlled substance consisting of oxycodone and acetaminophen used to treat moderate to severe pain) 10mg/325mg take 1 tablet every 6 hours.<br><br>Review of Resident #8's physician's order revealed a physician's order dated 12/20/19 changing Percocet 10/325 to oxycodone 10mg (a controlled substance used to treat moderate to severe pain) take 1 tablet every 6 hours as needed for pain.<br><br>Observation of medication pass on 01/07/20 at 12:13pm revealed the medication aide (MA) administered an oxycodone 10mg tablet to Resident #8 outside of the medication room without the resident asking for medication.<br><br>Review of Resident #8's December 2019 electronic Medication Administration Record (eMAR) revealed:<br>-There was a computer-generated entry for | D 367 | | |

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| D 367 | Continued From page 24<br><br>Percocet 10/325 take 1 tablet by mouth 4 times daily scheduled to administer at 8:00am, 12:00pm, 4:00pm, and 8:00pm.<br>-Percocet 10/325 was documented as administered 4 times daily at 8:00am, 12:00pm, 4:00pm, and 8:00pm from 12/01/19 to 12/31/19 except for 12/06/19, 12/10/19-12/11/19, 12/16/19-12/17/19, 12/22/19-12/24/19 when the resident was out of the facility.<br>-There was a computer-generated entry for oxycodone 10mg take 1 tablet every 6 hours as needed with a started date of 12/20/19.<br>-There was no documentation that oxycodone 10mg was administered from 12/20/19-12/31/19.<br>-There was no documentation related to the effectiveness of each administered dose of oxycodone 10mg.<br><br>Review of Resident #8's January 2020 eMAR revealed:<br>-There was a computer-generated entry for Percocet 10/325 take 1 tablet by mouth 4 times daily scheduled to administer at 8:00am, 12:00pm, 4:00pm, and 8:00pm.<br>-Percocet 10/325 was documented as administered 4 times daily at 8:00am, 12:00pm, 4:00pm, and 8:00pm from 01/01/20-01/07/20 except for 01/05/20-01/06/20 when the resident was out of the facility.<br>-There was a computer-generated entry for oxycodone 10mg take 1 tablet every 6 hours as needed.<br>-There was no documentation that oxycodone 10mg was administered from 01/01/20-01/07/20.<br>-There was no documentation related to the effectiveness of each administered dose of oxycodone 10mg.<br><br>Observation of medications on hand for Resident #8 on 01/07/20 at 3:40pm revealed: | D 367 | | |

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| D 367 | Continued From page 25<br>-There were 2 medication cards of oxycodone 10mg available to administer dispensed on 12/20/19.<br>-One medication card contained 30 tablets of oxycodone 10mg and the other medication card contained 19 tablets for a total number of tablets remaining of 49 tablets.<br>-There was no Percocet 10/325 available to administer.<br><br>Telephone interview with a pharmacist from Resident #8's pharmacy on 01/07/20 at 3:21pm revealed:<br>-The pharmacist dispensed 120 tablets of oxycodone 10mg with directions to take 1 tablet every 6 hours as needed to Resident #8 on 12/20/19.<br>-The pharmacy last dispensed 120 tablets of Percocet 10/325 to Resident #8 on 11/22/19 for a 30-day supply.<br>-The pharmacy was not responsible for updating Resident #8's eMAR.<br><br>Telephone interview with a pharmacy technician with the facility's contracted pharmacy on 01/08/20 at 9:06am revealed the pharmacy did not dispense any medications to Resident #8 but was responsible for updating the eMAR.<br><br>Interview with Resident #8 on 01/09/20 at 10:45am revealed:<br>-The doctor had changed her pain medication because of the pharmacy.<br>-She did not know she had to ask for the oxycodone until recently<br>-She had always taken her pain medication as scheduled.<br><br>a. Interview with a medication aide (MA) on 01/07/20 at 3:45pm revealed she did not know | D 367 | | |

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| D 367 | Continued From page 26<br>the Percocet had been discontinued and changed to oxycodone.<br><br>Interview with a medication aide (MA) on 01/09/20 at 11:10am revealed:<br>-She did not know Resident #8 had a physician's order for oxycodone 10mg as needed.<br>-She was documenting the oxycodone 10mg under the entry for Percocet on the eMAR.<br>-The MAs were responsible for comparing the label of all new medications to the eMAR before putting the medication on the medication cart to administer to the residents.<br><br>Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/08/20 at 8:14am revealed:<br>-The pharmacy was responsible for removing discontinued medications from the eMAR.<br>-The pharmacy had not received a discontinuation order for Percocet 10/325 for Resident #8 so the order remained on the eMAR.<br>-The facility staff could make changes to the eMAR but the facility was advised to let the pharmacy complete all the data entry for the eMARs.<br>-The pharmacy had to have a discontinuation order before the Percocet could be discontinued from the eMAR.<br>-Resident #8 could be prescribed the Percocet on schedule and the oxycodone as needed.<br>-The facility was responsible for calling the provider to get a discontinuation order faxed to the pharmacy.<br><br>Interview with the Resident Care Coordinator (RCC) on 01/09/20 at 12:56pm revealed:<br>-She did not know Resident #8's pain medication order had changed until 12/27/19 when she was administering medications. | D 367 | | |

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| D 367 | Continued From page 27<br>-She faxed the medication order to the facility's contracted pharmacy on 12/27/19 for the order to be added to the eMAR.<br>-The pharmacy would not remove the Percocet order from the eMAR because they did not have an order to discontinue the medication.<br>-She was responsible for contacting the provider to obtain an order to discontinue the medication.<br>-She had not been able to get an order to discontinue the Percocet because the provider was on vacation.<br>-She was responsible for checking behind the MAs to make sure all discontinued medications were removed from the medication cart and returned to the pharmacy.<br><br>Telephone interview with a nurse from Resident #8's primary care provider's (PCP) office on 01/08/20 at 2:45pm revealed:<br>-Resident #8's Percocet 10/325 take 1 tablet 4 times daily was changed to oxycodone 10mg take 1 tablet every 6 hours as needed.<br>-The facility staff had not contacted the office for a discontinuation order for the Percocet.<br>-The PCP was out of the office, but another provider was available to write the discontinuation order.<br><br>Interview with the Administrator on 01/09/20 at 11:40am revealed:<br>-She did not know Resident #8's medication order for Percocet was not removed from the eMAR.<br>-She did not know the pharmacy would not accept the order to change Resident #8's Percocet to oxycodone as a discontinuation order.<br>-The RCC was responsible for contacting the physician to obtain a discontinuation order and faxing the order to the pharmacy to update the eMAR. | D 367 | | |

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| D 367 | Continued From page 28<br><br>b. Interview with a medication aide (MA) on 01/09/20 at 11:10am revealed:<br>-Resident #8 was administered the oxycodone 10mg on schedule daily at 8:00am, 12:00pm, 4:00pm, and 8:00pm.<br>-She did not know Resident #8 had an order for oxycodone 10mg as needed.<br>-She did not know the oxycodone 10mg was listed on the eMAR as a separate order.<br>-She did not know the oxycodone 10mg was documented on an entry on the eMAR for Percocet 10/325.<br>-The MAs were responsible for reading the label on the medication and comparing it to the eMAR to make sure the correct medication was administered correctly.<br><br>Review of Resident #8's December 2019 Control Substance Inventory Log for Percocet 10/325mg revealed the last tablet was administered on 12/20/19 at 8:00am.<br><br>Review of Resident #8's December 2019 and January 2020 Control Substance Inventory Log for oxycodone 10mg revealed:<br>-The first tablet of oxycodone 10mg was administered on 12/22/19 at 12:00pm.<br>-There was documentation of 71 tablets of oxycodone 10mg being administered to Resident #8 with 49 tablets remaining in the facility.<br><br>Interview with the Resident Care Coordinator (RCC) on 01/09/20 at 12:56pm revealed:<br>-She did not know Resident #8's pain medication order had changed until 12/27/19 when she was administering medications.<br>-She found the order for the oxycodone 10mg in the medication room.<br>-She called Resident #8's POA and found out the | D 367 | | |

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| D 367 | Continued From page 29<br><br>POA had delivered the oxycodone 10mg and a copy of the medication order to the facility on 12/20/19.<br>-The MA did not fax the medication order to the pharmacy when the POA gave her the order for the oxycodone.<br>-The oxycodone was available to administer and not the Percocet.<br>-She faxed the medication order to the facility's contracted pharmacy on 12/27/19 for the order to be added to the eMAR.<br>-The MAs had started administering the oxycodone 10mg tablets once the Percocet tablets were not available on the medication cart.<br><br>Telephone interview with a nurse from Resident #8's primary care provider's (PCP) office on 01/08/20 at 2:45pm revealed:<br>-Resident #8's Percocet 10/325 take 1 tablet 4 times daily was changed to oxycodone 10mg take 1 tablet every 6 hours as needed.<br>-The facility staff should not be administering the oxycodone on a regular schedule.<br>-The provider expected the facility to only administer the oxycodone when the resident requested the medication.<br><br>Interview with the Administrator on 01/09/20 at 11:40am revealed:<br>-She did not know Resident #8's oxycodone was being administered on a schedule when the order was written for as needed administration.<br>-The RCC or MAs were responsible for faxing new medication orders to the pharmacy and making a copy of each order for the new physician's orders notebook.<br>-The MAs were responsible for checking the medication once it was delivered to the eMAR to make sure the label matched the eMAR.<br>-The MAs were responsible for administering | D 367 | | |

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| D 367 | Continued From page 30<br>medications based on the eMAR.<br><br>c. Review of facility's Medication Administration Policy revealed:<br>-The administration of an as needed medication required some evaluation of the resident's condition.<br>-The eMAR must include some justification and directions for their use.<br>-The facility staff administering the as needed medication was responsible for initialing the appropriate date space on the eMAR each time the medication was administered.<br>-Each administered as needed medication must have the following documented on the eMAR, date, time, reason, medication, route of medication, site of injection if applicable, results obtained including time, and initials of staff person.<br><br>Interview with a medication aide (MA) on 01/09/20 at 11:10am revealed:<br>-She did not know Resident #8 had a physician's order for oxycodone 10mg as needed.<br>-The MAs were responsible for documenting the effectiveness and the result of all administered as needed medications.<br>-She was documenting the oxycodone 10mg under the entry for Percocet on the eMAR and had not documented any of the required information on the eMAR related to an as needed medication.<br><br>Interview with the Resident Care Coordinator (RCC) on 01/09/20 at 12:56pm revealed:<br>-She did not know the MAs were not documenting the required information for Resident #8's as needed medication order.<br>-She and the MAs were responsible for auditing the eMARs to make sure all orders were correct. | D 367 | | |

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| D 367 | Continued From page 31<br>-The MAs were responsible for documenting the required information for as needed medications on the eMAR.<br>-She would randomly audit the eMARs to make sure all the information was documented on as needed medication orders.<br><br>Interview with the Administrator on 01/09/20 at 11:40am revealed:<br>-She did not know the MAs were not correctly documenting the administration of an as needed medication to Resident #8.<br>-The MAs were responsible for documenting the required information on the eMAR for each dose of an as needed medication administered.<br>-The RCC was responsible for approving orders for the eMAR and auditing the eMARs as needed to make sure they were correct, including the documentation associated with as needed medications. | D 367 | | |
| D 372 | 10A NCAC 13F .1004 (o) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br><br>(o) A resident's medication shall not be administered to another resident except in an emergency. In the event of an emergency, the borrowed medications shall be replaced promptly and the borrowing and replacement of the medication shall be documented.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to assure 1 of 7 | D 372 | | |

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| D 372 | Continued From page 32<br>residents observed during the medication pass (Resident #9) only received borrowed medications in an emergency.<br><br>The findings are:<br><br>Review of Resident #9's current FL2 dated 12/26/19 revealed:<br>-Diagnoses included diabetes, hypertension, chronic kidney disease, atrial fibrillation, and peripheral artery disease.<br>-There was a physician's order for Novolin R (a fast-acting insulin used to treat diabetes) check and record blood sugar before meals and inject per sliding scale 200-249 give 2 units, 250-299 give 4 units, 300-349 give 6 units, 350-400 give 8 units.<br><br>Observation of medication pass on 01/07/20 at 12:25pm revealed:<br>-Resident #9 came to the medication room to get his fingerstick blood sugar (FSBS) checked before lunch.<br>-Resident #9's FSBS was 328.<br>-The medication aide (MA) picked up a vial of Novolin R sitting on top of the medication cart and wiped the vial with an alcohol swab.<br>-The MA used an insulin syringe to draw up the dose and administered 6 units of Novolin R to Resident #9.<br>-The MA put the vial of Novolin R back on the top of the medication cart.<br>-The vial of Novolin R had another resident's name on the label and did not belong to Resident #9.<br><br>Interview with the MA at 12:27pm revealed:<br>-She did not know she had administered another resident's insulin to Resident #9.<br>-She had grabbed the vial of insulin from the top | D 372 | Human Resource Manager and Care Coordinator will ensure all med-techs have received proper training on the 8 steps of medication administration.<br><br>Care Coordinators will monitor staff weekly and RN will monitor staff monthly effective 1/21/20. | |

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| D 372 | Continued From page 33<br>of the medication cart and did not realize it was not Resident #9's insulin.<br>-She knew the vial of insulin was the correct type of insulin that she needed to administer to Resident #9.<br>-She did not read the label on the insulin vial or the box before she administered the insulin to Resident #9.<br>-She was responsible for reading the label on the medication and comparing it the electronic Medication Administration Record (eMAR) before she administered the medication.<br>-She was not paying attention to the label on the medication and administered the wrong resident's insulin to Resident #9.<br><br>Observation of medications on hand for Resident #9 revealed there was a partially used vial of Novolin R in the medication cart dispensed to Resident #9 on 12/08/19 from the facility's contracted pharmacy.<br><br>Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/08/20 at 9:06am revealed the pharmacy dispensed one 10 ml vial of Novolin R to Resident #9 with the directions to check FSBS before meals and administer as directed per sliding scale for a 30 day supply.<br><br>Interview with the Resident Care Coordinator (RCC) on 01/07/20 at 12:45pm revealed:<br>-The MA should not be administering a resident's medication to another resident.<br>-The MAs were responsible to look at the label on the medication to make sure they were administering the correct medication to each resident.<br>-The MAs were responsible for comparing the medication label with the eMAR. | D 372 | | |

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| D 372 | Continued From page 34<br><br>Telephone interview with Resident #9's Nurse Practitioner (NP) on 01/08/20 at 3:45pm revealed:<br>-The MAs should not be sharing medications among residents.<br>-The MAs were responsible for making sure they administered the correct medication and the correct dose to the correct resident.<br><br>Interview with the Administrator on 01/09/20 at 11:40am revealed:<br>-The MAs were responsible for administering medications based on the eMAR.<br>-The MAs were responsible for scanning each medication before administration to make sure it was the correct medication for the correct resident.<br>-The MAs were responsible for reading the medication label and comparing it to the eMAR before administering the medication. | D 372 | | |
| D932 | G.S. 131D-4.4A (b) ACH Infection Prevention Requirements<br><br>G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements<br><br>(b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012:<br>(1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following:<br>a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple | D932 | | |

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| D932 | Continued From page 35<br>residents.<br>b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules.<br>c. Accessibility of infection control devices and supplies.<br>d. Blood and bodily fluid precautions.<br>e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens.<br>f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves.<br>(2) Require and monitor compliance with the facility's infection control policy.<br>(3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens.<br><br>This Rule is not met as evidenced by:<br>Based on observations and interviews, the facility failed to implement an infection control policy | D932 | Human Resource Manager will ensure that each staff member receive annual infection control training.<br><br>All management will monitor med-techs weekly to ensure that all infection prevention is followed.<br><br>Care Coordinators will complete monthly medication pass audits.<br><br>Effective 1/20/20. | |

| 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 _____ | R-C 01/09/2020 |

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

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| D932 | Continued From page 36<br>consistent with the Centers for Disease Control and Prevention guidelines to ensure proper infection control procedures were followed related to 1 medication aide (Staff B) not wearing gloves during the administration of insulin.<br><br>The findings are:<br><br>Observation of the morning medication pass on 01/07/20 at 12:19pm revealed:<br>-The medication aide (MA) checked a resident's fingerstick blood sugar (FSBS) in the medication room and was preparing to administering insulin.<br>-The MA had gloves on while she checked the resident's FSBS but removed the gloves and washed her hands with hand sanitizer located on the medication cart before she removed the resident's insulin from the medication cart.<br>-The MA swabbed the resident's right upper arm with an alcohol pad.<br>-The MA swabbed the top of the insulin vial with an alcohol pad and drew up 11 units of insulin.<br>-She administered the insulin to the resident without putting on another pair of gloves.<br>-The MA called another resident into the medication room to get his FSBS checked.<br>-The MA put on gloves and checked the other residen'ts FSBS.<br>-The MA removed the gloves and washed her hands with hand sanitizer.<br>-The MA picked up insulin from the top of the medication cart to administer to the other resident.<br>-The MA swabbed the other resident's right upper arm with an alcohol pad.<br>-The MA swabbed the top of the insulin vial with an alcohol pad and drew up 6 units of insulin.<br>-She administered the insulin to the other resident without putting on another pair of gloves.<br>-The MA washed her hands again with hand | D932 | | |

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| D932 | Continued From page 37<br>sanitizer.<br><br>Review of the facility's Infection Control Policy revealed:<br>-The facility was responsible for supplying disposable gloves, hand sanitizer, handwashing stations to the staff at all times.<br>-The facility staff should wear gloves and follow universal precautions.<br><br>Observation of the medication cart on 01/07/20 at 12:30pm revealed there was 1 box of gloves available for the staff to use.<br><br>Interview with Staff B on 01/07/20 at 12:27pm revealed:<br>-She had worked as a MA for about a year and a half.<br>-She did not know that she was supposed to wear gloves when she administered insulin to a resident.<br>-She did not remember if she was ever told to wear gloves during insulin administration, but "she might have been told."<br>-She always wore gloves when she checked a residents FSBS.<br>-She did not know why she did not wear gloves to administer insulin.<br><br>Interview with another MA on 01/08/20 at 9:45am revealed she was taught to always wear gloves during insulin administration in her diabetic and infection control training.<br><br>Interview with the Resident Care Coordinator (RCC) on 01/09/20 at 12:56pm revealed:<br>-She did not know Staff B was not wearing gloves to administer insulin.<br>-She expected all MAs to wear gloves when they checked a resident's FSBS or administered | D932 | | |

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| D932 | Continued From page 38<br>insulin.<br><br>Telephone interview with the Nurse Consultant Manager from the facility's contracted pharmacy on 01/09/20 at 12:50pm revealed:<br>-She was responsible for the Nurse Consultants that provided diabetic training to the facility.<br>-The diabetic training was completed online with a return demonstration completed at the facility.<br>-The diabetic training instructed all MAs to wear gloves every time the MA encountered bodily fluids.<br>-The MA was responsible for washing their hands before and after insulin administration and for wearing gloves during the administration.<br>-The MA was increasing the risk to herself and the resident of spreading blood borne pathogens if she did not wear gloves.<br><br>Telephone interview with the facility's contracted Nurse Practitioner (NP) on 01/08/20 at 3:45pm revealed:<br>-The MAs should always wear gloves when they are exposed to bodily fluids, including during FSBS checks and insulin administration.<br>-The MA and the resident were at an increased risk of infection due to the exposure to bodily fluids.<br><br>Interview with the Administrator on 01/09/20 at 11:40am revealed:<br>-She did not know Staff B was not wearing gloves when administering insulin.<br>-She expected the MAs to wear gloves when they administered insulin.<br>-The MAs were responsible for completing annual infection control and diabetic training. | D932 | | |