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
	HAL031019	A. BUILDING: _____ B. WING _____	R 06/24/2022

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

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on June 22-24, 2022.	D 000	Responses to these cited deficiencies do not constitute an admission or agreement by the facility or the truth of the facts alleged or conculsion set forth in the Statement of Deficiencie, the plan of correction is prepared soley as a matter of compliance with state law.	
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by the primary care provider for 1 of 4 residents (#7) observed during the medication passes including errors with topical pain medications. The findings are: The medication error rate was 7% as evidenced by the observation of 2 errors out of 28 opportunities during the 9:00am medication pass on 06/23/22. Review of Resident #7's current FL-2 dated 06/08/22 revealed: -Diagnoses included atrial fibrillation, dementia, hypertension, chronic obstructive pulmonary disease, delirium, osteoarthritis, communication deficit, muscle weakness, hearing loss, legal blindness, insomnia and a history of falls.	D 358	Executive Director and /or Area Clinical Director will perform medication observation passes weekly x 4 weeks, twice a month x4 weeks then monthly thereafter. ED and/or ACD observations will include the application of creams as order and the application of any patch(s) as ordered, observing residents take their medication before the MT leaves the room and recording on the electronic eMAR once pass to the resident is completed.	7/25/2022 and on-going

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Linda Edge — TITLE: ED — (X6) DATE: 7/25/22

STATE FORM 6899 PF4111 If continuation sheet 1 of 12

Reviewed and acknowledged 01 August 2022 Susan Hare

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D 358	Continued From page 1 -Medication orders included diclofenac 1% cream apply to both hips and knees four times daily and Icy Hot 5% transdermal apply to affected hip and knee daily and remove every evening. (Diclofenac was used to treat muscle and joint pain and Icy Hot was used to treat muscle and joint pain.) Interview with the medication aide (MA) on 06/23/22 at 8:40am revealed: -She had administered all of Resident #7's morning medications except for patches (Icy Hot) that were applied to his knees. -She planned to put them on the resident after he finished his breakfast. Observation on 06/23/22 at 9:50am revealed the MA placed an Icy Hot patch on each of Resident #7's knees. Observation of medications on hand for Resident #7 on 06/23/22 at 11:21am revealed: -There was a plastic bag containing a manufacturer's package of Icy Hot and a prescription label for with instructions to apply patches to the affected hip and knee daily and remove every evening. -There was a plastic bag containing a tube of diclofenac cream and a prescription label with instructions to apply to both hips and knees four times daily. Review of Resident #7's 06/23/22 electronic medication administration record (eMAR) revealed: -There was an entry for diclofenac cream 1% apply to both hips and knees four times daily at 9:00am, 1:00pm, 5:00pm and 9:00pm. -There was no documentation a dose was administered on 06/23/22. -There was an entry for Icy Hot 5% patch apply to	D 358		

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D 358	Continued From page 2 affected hip and knee daily and remove every evening. -The patch was scheduled for 9:00am daily; there was no scheduled time to remove the patch. Interview with Resident #7 on 06/23/22 at 11:13am revealed: -He was "full of arthritis" and hurt all over from his hip to his feet. -He wore the patches on his knees. -The MAs did not put the patches on his hips; they put the cream on his hips. -The cream and patches calmed the arthritis pain "a little bit" but no one could get rid of arthritis pain. Interview with the MA on 06/23/22 at 11:21am revealed: -She did not know about the instructions to apply a patch to Resident #7's left hip and left knee. -She had always put the patches on his knees. -She did not put the cream on at 9:00am because then she would not have been able to put the patches on. -The patches would not stick after the cream was applied. -She put the patches on at 9:00am daily and removed them at 12:00pm daily to apply the cream scheduled at 1:00pm. -She did not know the patches were to applied every morning and removed every evening. Interview with a second MA on 06/23/22 at 11:23am revealed: -She usually put the cream on Resident #7's knees at 9:00am and let it dry before applying the patches. -At 1:00pm she removed the patches and applied the cream again. -The patches could not be replaced after the	D 358		

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D 358	Continued From page 3 1:00pm cream because they would not stick. -She only applied cream to his knees and not to his hips. -Reviewing the orders and what they had been doing made her think the orders needed to be clarified. Telephone interview with Resident #7's primary care provider (PCP) on 06/24/22 at 11:50am revealed the cream and patches were not effective in relieving Resident #7's arthritis pain if they were not on as ordered. Interview with the Resident Care Coordinator (RCC) on 06/24/22 at 3:15pm revealed: -The MA should have read the directions on the eMAR and medication labels for the topical pain relievers. -The orders should have been clarified on administering cream four times daily with patches in place. -MAs normally brought unclear orders to her attention for follow up with the PCP. -It was not brought to her attention prior to 06/23/22. Interview with the Administrator on 06/24/22 at 3:43pm revealed: -She was not aware of how the cream and patch were being administered to Resident #7. -MAs should have read instructions on the label and eMAR and notified the RCC. -The RCC would have then contacted the PCP for clarification of the orders.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 366		

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D 366	Continued From page 4 (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 observations, interviews and record reviews, the medication staff failed to ensure medication aides observed residents with taking their morning medications for 2 of 2 residents (#1 and #6) on 06/22/22 and 06/23/22. The findings are: 1. Review of Resident #6's current FL-2 dated 05/16/22 revealed diagnoses included unspecified diastolic congestive heart failure, Parkinson's disease, chronic obstructive pulmonary disease, hypertension, anxiety, stage 3 chronic kidney disease, Meniere's disease and gastroesophageal reflux disease. Review of Resident #6's physician orders dated 05/25/22 revealed: -There was an order for Acetaminophen 325mg tablet, take 2 tablets three times a day. (Acetaminophen is used to treat mild to moderate pain.) -There was an order for Benzonatate 100mg capsule, take 2 capsules by mouth every 4 hours as needed for cough. (Benzonatate is used to relieve coughing.) -There was an order for Carbidopa-Levodopa	D 366	Area clinical director will conduct in-service/ retraining on July 25, 2022 regarding: -recording of medication administration on electronic MAR following administration of the medication to resident -observing the resident take the medication before proceeding to next resident or before leaving room -verify the medication/patch alongside the electronic MAR before administration.	7/25/2022 and on-going

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D 366	Continued From page 5 25-100mg tablet, take ½ tablet twice a day. (Carbidopa-Levodopa is a combination medication used to treat symptoms of Parkinson's disease, such as stiffness or tremors.) -There was an order for Ferrous Sulfate 142mg extended release tablet, take 1 tablet every morning. (Ferrous Sulfate is used to treat and prevent iron deficiency anemia.) -There was an order for Fexofenadine 180mg tablet, take 1 tablet every morning. (Fexofenadine is an antihistamine and is used to relieve the symptoms of hay fever and seasonal allergies.) -There was an order for Ibuprofen 200mg tablet, take 2 tablets three times a day. (Ibuprofen is used to reduce fever and treat pain or inflammation.) -There was an order for Pantoprazole 20mg delayed release tablet, take 2 tablets twice a day. (Pantoprazole is used to treat damage from gastroesophageal reflux disease.) -There was an order for Umeclidinium blister with device 62.5mcg/actuation, one puff into lungs every morning. (Umeclidinium is used in adults to control wheezing, shortness of breath, coughing, and chest tightness caused by chronic obstructive pulmonary disease.) Review of Resident #1's physician orders dated 06/02/22 revealed an order for Propranolol 20mg tablet, take ½ tablet twice a day. (Propranolol is used to treat high blood pressure, irregular heart rhythms, certain types of tremor, and to prevent chest pain.) Review of Resident #6's June 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Acetaminophen 325mg tablet, take 2 tablets three times a day, scheduled	D 366		

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D 366	Continued From page 6 for 9:00am. -Acetaminophen was documented as administered to the resident on 06/23/22 at 9:00am. -There was an order for Benzonatate 100mg capsule, take 2 capsules by mouth every 4 hours as needed for cough. -Benzonatate was documented as administered to the resident on 06/23/22 at 8:37am. -There was an order for Carbidopa-Levodopa 25-100mg tablet, take ½ tablet twice a day, scheduled for 9:00am. -Carbidopa-Levodopa was documented as administered to the resident on 06/23/22 at 9:00am. -There was an order for Ferrous Sulfate 142mg extended release tablet, take 1 tablet every morning, scheduled for 9:00am. -Ferrous Sulfate was documented as administered to the resident on 06/23/22 at 9:00am. -There was an order for Fexofenadine 180mg tablet, take 1 tablet every morning, scheduled for 9:00am. -Fexofenadine was documented as administered to the resident on 06/23/22 at 9:00am. -There was an order for Ibuprofen 200mg tablet, take 2 tablets three times a day, scheduled for 9:00am. -Ibuprofen was documented as administered to the resident on 06/23/22 at 9:00am. -There was an order for Pantoprazole 20mg delayed release tablet, take 2 tablets twice a day, scheduled for 9:00am. Pantoprazole was documented as administered to the resident on 06/23/22 at 9:00am. -There was an order for Propranolol 20mg tablet, take ½ tablet twice a day, scheduled for 9:00am. -Propranolol was documented as administered to the resident on 06/23/22 at 9:00am.	D 366		

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D 366	Continued From page 7 -There was an order for Umeclidinium blister with inhaler 62.5mcg/actuation, one puff into lungs every morning, scheduled for 9:00am. -Umeclidinium was documented as administered to the resident on 06/23/22 at 9:00am. Observation of Resident #6 during the breakfast mealtime on 06/23/22 revealed: -The resident received her breakfast in her room at 8:25am. -The dietary staff placed her meal tray on a wooden tray stand in front of the resident while she sat in her recliner. -There was a plastic medication cup containing multiple halved pills and a plastic medication cup with applesauce located on the wooden try stand next to her food tray. -The medication aide (MA) was not in the resident's room when her food tray was delivered and set down beside the plastic medications cups. -The MA returned to the resident's room, administered the resident an inhaler medication at approximately 8:30am, and then left the room. -The resident unfolded and placed a white napkin in her lap, then she poured the halved pills onto the napkin. -There were approximately 18 pill halves on the resident's napkins. -The resident scooped up a small amount of applesauce onto the spoon, placed 1-2 pill halves onto the applesauce, and self-administered all the pill halves between 8:30 - 8:40am. Interview with Resident #6 on 06/23/22 at 8:40am revealed: -Her morning and afternoon medications were often left in her room by the MA. -She used the applesauce to make swallowing the medication easier.	D 366		

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D 366	Continued From page 8 -She placed the pill halves onto a napkin in her lap because it was easier to pick them up that way. -She was very careful, so she did not drop any pills because sometimes she had hand tremors. Attempted telephone interview with the MA on 06/24/22 at 11:43pm was unsuccessful. Interview with a second MA on 06/23/22 at 10:35am revealed: -Some residents wanted to take their pills with pudding or applesauce. -MAs were not supposed to leave the medications in the resident's room without watching them take the medications. -She did not recall if she ever left medications in the resident's room for them to take without her observing.	D 366		
	Interview with Resident #6's primary care provider (PCP) on 06/24/22 at 11:50am revealed she was not concerned about the resident taking her medications on her own. Interview with the Resident Care Coordinator (RCC) on 06/24/22 at 3:15pm revealed: -The MAs should not leave medications in the residents' rooms. -The MAs should have observed Resident #6 take her medications before she documented in the resident's eMAR. Interview with the Administrator on 06/24/22 at 3:43pm revealed: -The MAs should not leave medications in the residents' rooms. -The MAs should watch the residents take their medications before they were documented in the resident's eMAR.			

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D 366	Continued From page 9 2. Review of Resident #1's current FL-2 dated 01/05/22 revealed: -Diagnoses included history of right patella and tibia fractures, coronary artery disease, chronic stabile angina, hypertension, physical deconditioning and hypothyroidism. -Medication orders included acetaminophen 325mg two tablets twice daily (used to treat pain), aspirin 81mg daily (used to prevent blood clots), atorvastatin 40mg daily (used to treat high cholesterol), calcium carbonate 600mg twice daily (replacement supplement), clopidogrel 75mg daily (used to prevent blood clots), docusate 100mg daily (used to treat constipation), vitamin D2 50mcg daily (replacement supplement), isosorbide mononitrate extended release (ER) 30mg daily (used to treat angina), loratadine 10mg daily (used to treat allergy symptoms), metoprolol 25mg daily (used to treat high blood pressure), and multivitamin 1 tablet daily (replacement supplement). Review of Resident #1's June 2022 electronic medication administration record (eMAR) revealed: -The following medications were scheduled for administration at 9:00am and documented as administered on 06/22/22: -Acetaminophen 325mg two tablets, aspirin 81mg, atorvastatin 40mg, calcium carbonate 600mg, clopidogrel 75mg, docusate 100mg, vitamin D2 50mcg, isosorbide mononitrate ER 30mg daily, loratadine 10mg daily, metoprolol 25mg daily, and a multivitamin tablet daily. Observations during the tour of the facility on 06/22/22 at 9:01am revealed: -Resident #1 was sitting at the edge of her bed with a side table next to her bed.	D 366		

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D 366	Continued From page 10 -The table had a meal tray with beverages and a plastic medication cup containing several pills. -The medication aide (MA) returned to the room with a breakfast plate. -The MA told the resident that her breakfast had been reheated and sat down in the recliner in the resident's room. -The MA told the resident she would have to stay to watch her take her medications. Interview with the MA on 06/22/22 at 9:04am revealed: -She had stepped out of Resident #1's room to reheat her breakfast for a minute. -She had just set the medications down to reheat the plate of food. -The resident was moving slower that morning and needed more time to take her medications. -She planned to sit and watch her take her medications after reheating her food. Telephone interview with Resident #1's primary care provider (PCP) on 06/24/22 at 11:50am revealed Resident #1 needed assistance with taking medications due to a cognitive and physical decline. Interview with the Resident Care Coordinator (RCC) on 06/24/22 at 3:15pm revealed: -Medications should not be left at the bedside for residents. -The MA should have taken the medications with her when she left the room to warm up the food. Interview with the Administrator on 06/24/22 at 3:43pm revealed: -Medications should not be left in the room with a resident. -MAs should have observed the resident take their medications before leaving the room.	D 366		

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D 366	Continued From page 11 Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable.	D 366		