STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL082022	A. BUILDING: _____ B. WING _____	C 04/04/2023

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THE MAGNOLIA	213 FOREST TRAIL CLINTON, NC 28328

(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 04/03/23 - 04/04/23. The complaint investigation was initiated by the Sampson County Department of Social Services on 03/29/23.	D 000		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that a resident's thickened liquids (#4) were served as ordered as evidenced by the kitchen staff not measuring the thickened liquids as directed and serving the resident the incorrect thickened consistency. The findings are: Review of Resident #4's FL-2 dated 07/25/22 revealed diagnoses included dementia, Parkinson's disease, type 2 diabetes, schizophrenia, angioedema, tremors, epistaxis, and gastrointestinal reflux disease. Review of Resident #4's physician's order dated 03/01/23 revealed a downgrade in his diet to puree with nectar thickened liquids. Observation of the breakfast meal on 04/04/23 between 7:30am and 8:15am revealed Resident #4 was served thickened water in a cup,	D 310		

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thickened milk in a cup and prepackaged honey consistency apple juice in its original carton.

Review of the thickened powder package label revealed:
-Add one packet thickening powder to 4 ounces of liquid.
-Stir with a spoon or fork for approximately 15 seconds or until thickener was dissolved.
-When mixed with 4 ounces of water, coffee, and clear juices, the beverage consistency was nectar.
-When mixed with 4 ounces of orange juice and milk, the beverage consistency was honey.

Observation of a kitchen staff preparing nectar thickened water from a thickening powder packet on 04/04/23 at 8:15am revealed:
-There was no liquid measuring cup used to add water to an 8 ounce cup.
-The thickened powder packet was added to the cup of water.
-The directions on the thickened powder packet were not used.

Interview with the kitchen staff on 04/04/23 at 8:15am revealed:
-She prepared the thickened water for Resident #4's breakfast using the packet.
-She did not use a liquid measuring cup to ensure the precise amount of liquid, which would determine the amount of thickener to be added to achieve the nectar consistency.
-She usually added about 6 ½ ounces of water when preparing the thickened liquids.
-The medication aide directed her to measure 6 ½ ounces of a liquid when making thickened liquids.
-She previously read the label on the back of the thickened powder package and it read to use 4

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D 310	Continued From page 2 ounces of water. -She thought the 6 ½ ounces of water was accurate because the 4 ounces of water made it too thick. -She gave the resident prepackaged honey consistency apple juice this morning because that was what she always him. -She did not know it mattered if Resident #4 received honey or nectar thickened powder or beverages because no one explained the difference between the two. Interview with the Dietary Manager on 04/04/23 at 8:15am revealed: -The kitchen staff used thickened powder packets when the prepackaged thickened beverages were not available. -There was not a liquid measuring cup in the kitchen to ensure the precise amount of liquid, which would determine the amount of thickener to be added to achieve the nectar consistency. Interview with the Administrator on 04/04/23 at 8:38am revealed: -She expected the dietary manager to ensure the thickened liquids were served as ordered. -The kitchen staff were trained to accurately measure the thickened liquids.	D 310		
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	D 358		

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D 358	Continued From page 3 (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 ensure medications were administered as ordered for 1 of 3 residents (#6) observed during the medication pass including errors with a calcium supplement and a lubricant eye gel for dry, irritated eyes. The findings are: The medication error rate was 6% as evidenced by 2 errors out of 29 opportunities during the 8:00am medication pass on 04/04/23. a. Review of Resident #6's current FL-2 dated 03/24/23 revealed: -Diagnoses included diabetes mellitus, hypertension, hypercholesterolemia, anxiety disorder, major depressive disorder, gout, pain in right knee, and neuropathy. -There was an order for Calcium Carbonate 600mg 1 tablet twice a day. (Calcium Carbonate is a calcium supplement that may be used to treat and prevent bone loss.) Review of Resident #6's lab report dated 03/03/23 revealed the resident's calcium level was 9.1 (reference range 8.2 - 10.1). Review of Resident #6's April 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Calcium Carbonate 600mg take 1 tablet twice a day scheduled for 8:00am and 8:00pm. -Calcium Carbonate 600mg was documented as administered from 04/01/23 - 04/04/23 at 8:00am.	D 358		

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D 358	Continued From page 4 Observation of the 8:00am medication pass on 04/04/23 revealed: -The medication aide (MA) prepared 2 tablets from an over-the-counter (OTC) bottle of Calcium Citrate 600mg per serving. -According to the manufacturer label, one serving was 2 tablets which contained 600mg of Calcium Citrate (one tablet contained 300mg of Calcium Citrate). -The MA administered one tablet (300mg) of Calcium Citrate to Resident #6 at 7:29am instead of 600mg of Calcium Carbonate as ordered. (Calcium Citrate is a calcium supplement but is not the same as Calcium Carbonate.) Observations of Resident #6's medications on hand on 04/04/23 at 7:24am and 12:11pm revealed there was no Calcium Carbonate on hand for the resident. Interview with the MA on 04/04/23 at 12:11pm revealed: -Resident #6's family provided the resident's OTC medications to the facility. -The MA on duty or the Resident Care Coordinator (RCC) checked the OTC medications against the physician's orders and eMARs to make sure everything matched. -She did not notice Resident #6's OTC Calcium was Citrate instead of Carbonate or that the serving size was 2 tablets contained 600mg. -The resident did not have any Calcium Carbonate on hand. Interview with Resident #6 on 04/04/23 at 1:27pm revealed: -Her family usually mailed her OTC medications to the facility. -She had been taking calcium supplements since	D 358		

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she was in her early 20's for her bones.
-She was unsure which calcium supplement she was administered.

Interview with the RCC on 04/04/23 at 1:00pm revealed:
-Resident #6's family mailed the resident's OTC medications to the facility.
-If the OTC medications were received in the mail while she was on duty, she usually took the package to the resident's room and opened the package in front of the resident.
-She told the resident which medications were in the package and then put the medications in the medication cart.
-The MAs audited the medication carts weekly by checking the medications on hand and comparing it to the orders and the eMARs.
-If a medication did not match, the MAs should notify her, and she would notify the family.
-There was no system to document the OTC medications that were sent by the family to the facility.
-She had not noticed any discrepancies with Resident #6's OTC medications and no MAs had reported any discrepancies.

Interview with the Administrator on 04/04/23 at 1:14pm revealed:
-Resident #6's OTC medications were mailed to the facility by the family.
-The MAs should read the eMARs and compare the medication labels when administering medications.

Attempted telephone interview with Resident #6's family member on 04/04/23 at 3:08pm was unsuccessful.

Attempted telephone interview with Resident #6's

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primary care provider (PCP) on 04/04/23 at 3:10pm was unsuccessful.

b. Review of Resident #6's physician's order dated 03/24/23 revealed an order for GenTeal Tears Severe Gel 0.3% apply in each eye at bedtime. (GenTeal Tears Severe Gel is an eye gel used to relieve dry eye symptoms.)

Review of Resident #6's April 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for GenTeal Tears Severe Gel 0.3% apply in each eye at bedtime scheduled for 8:00pm.
-GenTeal Tears Severe Gel 0.3% was documented as administered at 8:00pm from 04/01/23 - 04/03/23.

Observation of the 8:00am medication pass on 04/04/23 revealed:
-The medication aide (MA) prepared and administered GenTeal Tears Severe Gel 0.3% to Resident #6's right eye at 7:31am.
-The resident was administered GenTeal Tears Severe Gel at 8:00am instead of 8:00pm at bedtime as ordered.
-The resident was administered GenTeal Tears Severe Gel in the right eye instead of both eyes as ordered.

Interview with the MA on 04/04/23 at 12:11pm revealed:
-She had always administered the GenTeal Tears Severe Gel in the right eye in the morning because that was the way it was ordered when the resident was admitted to the facility (could not recall date).
-She had not noticed the eMAR instructions were to administer GenTeal Tears Severe Gel in both

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eyes.
-She had not noticed the GenTeal Tears Severe Gel was scheduled to be administered at 8:00pm on the eMAR.
-The resident's eyes were usually "pretty red" in the mornings.

Interview with Resident #6 on 04/04/23 at 1:27pm revealed:
-She usually received GenTeal eye gel in both eyes twice a day.
-Last week her left eye stayed red all week.

Interview with the Resident Care Coordinator (RCC) on 04/04/23 at 1:00pm revealed:
-The MAs should read the eMARs and administer medications at the correct scheduled time.
-Resident #6 should have been administered the GenTeal Tears Severe Gel at 8:00pm, not 8:00am on 04/04/23.

Interview with the Administrator on 04/04/23 at 1:14pm revealed:
-The MAs should read the eMARs and compare the medication labels when administering medications.
-The MAs should only administer medications at the scheduled time.

Attempted telephone interview with Resident #6's primary care provider (PCP) on 04/04/23 at 3:10pm was unsuccessful.