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
	HAL093010	A. BUILDING: ______ B. WING ______	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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 a follow-up survey on May 14, 2024 to May 15, 2024.	D 000	D 273 pgs. 1-10 13F .0902(b) ED and RCC's shall meet with PCP at the end of each visit to exit. During this exit all new orders, referrals and new findings will be discussed to ensure everyone is aware of all follow-ups and referrals so that everything can be taken care of without delay. RCC's will handle all orders and referrals, ED will follow-up with RCC's to ensure all has been completed. Once RCC's have scheduled appointments they will make sure appointments are in the transportation book, their schedule book and on the calendar on ED wall. RCC's will schedule all labs to be done and will make sure ED is aware when they are scheduled. Once labs are completed they will be printed, and ED will be made aware. This will occur weekly and/or as often as referrals are made. Regional will make sure all appointments made match the Calander on ED wall and transportation book during weekly visits.	
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the health care needs for 2 of 5 sampled residents (#3 and #5) related to a pain management referral that was not completed (#3), not notifying the primary care provider (PCP) of a resident refusing fingerstick blood sugar (FSBS) checks and insulin (#3), and laboratory work not completed as ordered (#5). The findings are: 1. Review of Resident #3's current FL2 dated 01/29/24 revealed diagnoses included diabetes and bipolar mood. a. Review of Resident #3's signed physician orders dated 02/12/24 revealed there was an order to refer Resident #3 to pain management for chronic back pain. Review of Resident #3's signed physician orders dated 03/26/24 revealed there was an order to follow-up on referring Resident #3 to pain management for chronic back pain.	D 273		5/20/24

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shanee' Eley	Regional Assistant Director	6/14/24

Reviewed and acknowledged 06/14/24 kc

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Review of Resident #3's record revealed there was no documentation or appointment confirmation that Resident #3 was referred to pain management or a pain clinic.

Interview with Resident #3 on 05/15/24 at 3:40pm revealed:
-A provider referred her to pain management a couple of months ago but she had not heard anything else about it.
-She had chronic back pain and her pain level varied depending on the day.
-Her overall pain level had "been at her baseline" and had not worsened since February 2024.
-She had not been to a pain clinic or seen a provider specializing in pain management.

Telephone interview with Resident #3's primary care provider (PCP) on 05/15/24 at 4:15pm revealed:
-He was Resident #3's PCP since April 2024.
-Resident #3's previous PCP wrote the orders for the pain management referral and the follow-up order.
-The referral to pain management was for an external referral to a pain management clinic.
-Resident #3 had not been to a pain clinic to his knowledge.
-He planned to see Resident #3 specifically for a pain management visit in a couple of weeks.

Interview with the Resident Care Coordinator (RCC) on 05/15/24 at 1:40pm revealed:
-She did not know Resident #3 had an order for a referral to pain management in February and March 2024 because she was not working on the Assisted Living (AL) unit at that time.
-She reviewed provider visit notes.
-If there was an order for a referral, the normal

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process was for the RCC to search for a specific provider or specialist and called to see if they could make an appointment for the resident as soon as possible.

Interview with the Administrator on 05/15/24 at 4:55pm revealed:
-She did not know Resident #3 had an order for a pain management referral that was not completed.
-She expected provider orders to be completed.

b. Review of Resident #3's current FL2 dated 01/29/24 revealed there was an order to check FSBS twice daily.

Review of the facility's medication administration policy revealed the physician should be informed if a resident refuses medication for more than 2 days.

Review of Resident #3's March 2024 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for FSBS twice a day scheduled at 6:30am and 8:00pm.
-There were 14 of 62 FSBS opportunities documented as resident refused.
-Resident #3's FSBS values ranged from 78-184.

Review of Resident #3's April 2024 eMAR revealed:
-There was an entry for FSBS twice a day scheduled at 6:30am and 8:00pm.
-There were 25 of 60 FSBS opportunities documented as resident refused.
-Resident #3's FSBS values ranged from 109-373.

Review of Resident #3's May 2024 eMAR from

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05/01/24 to 05/14/24 revealed:
-There was an entry for FSBS twice a day scheduled at 6:30am and 8:00pm.
-There were 11 of 27 FSBS opportunities documented as resident refused.
-Resident #3's FSBS values ranged from 102-195.

Review of Resident #3's progress notes revealed there was not documentation the PCP was notified of FSBS refusals.

Telephone interview with Resident #3's PCP on 05/15/24 at 4:15pm revealed:
-He knew Resident #3 refused FSBS checks in March and April 2024 because he reviewed her eMARs during a visit to the facility in April 2024.
-He was not notified of any of Resident #3's FSBS refusals in May 2024.
-He expected the facility to notify him if Resident #3 refused FSBS checks after 3 consecutive days of refusals.

Interview with Resident #3 on 05/15/24 at 3:40pm revealed she sometimes refused her FSBS checks because she did not want her fingers stuck.

Interview with a medication aide (MA) on 05/15/24 at 1:15pm revealed:
-Resident #3 refused FSBS checks "a lot."
-She documented Resident #3 FSBS check refusals on the eMAR but she had not let anyone else know about Resident #3's FSBS check refusals, including the PCP.

Interview with the Resident Care Coordinator (RCC) on 05/15/24 at 1:40pm revealed:
-She did not know about any of Resident #3's FSBS refusals.

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-She expected MAs to let her know if a resident refused a FSBS check 3 times consecutively and she would reach out to the PCP to notify the PCP.

Interview with the Administrator on 05/15/24 at 4:55pm revealed:
-She did not know about any of Resident #3's FSBS refusals.
-She expected MAs to let her or the RCC know if a resident refused FSBS checks 3 times consecutively so the PCP could be notified.

c. Review of Resident #3's current FL2 dated 01/29/24 revealed there was an order for insulin glargine (a basal insulin used to maintain blood sugar levels) inject 35 units subcutaneously at bedtime.

Review of Resident #3's signed physician orders dated 02/05/24 revealed:
-There was an order for insulin glargine 100 units/mL inject 35 units subcutaneously every morning.
-There was an order for insulin glargine 100 units/mL inject 30 units subcutaneously at bedtime.

Review of Resident #3's laboratory results dated 01/25/24 revealed a Hemoglobin A1c (the average level of glucose in the blood over the past 3 months) value of 6.7% (normal range is between 4% and 5.9%)

Review of Resident #3's laboratory results dated 04/11/24 revealed a Hemoglobin A1c value of 7.4%.

Review of Resident #3's March 2024 eMAR revealed:
-There was an entry for insulin glargine 100

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units/ml inject 35 units subcutaneously every morning scheduled at 6:30am.
-There were 8 of 31 opportunities for insulin glargine morning administrations and documented as resident refused.
-There was an entry for insulin glargine 100 units/ml inject 30 units subcutaneously every evening scheduled at 8:00pm.
-There were 19 of 31 opportunities for insulin glargine evening administrations and documented as resident refused.
-Resident #3's FSBS values ranged from 78-184.

Review of Resident #3's April 2024 eMAR revealed:
-There was an entry for insulin glargine 100 units/ml inject 35 units subcutaneously every morning scheduled at 6:30am.
-There were 19 of 30 opportunities for insulin glargine morning administrations and documented as resident refused.
-There was an entry for insulin glargine 100 units/ml inject 30 units subcutaneously every evening scheduled at 8:00pm.
-There were 23 of 30 opportunities for insulin glargine evening administrations and documented as resident refused.
-Resident #3's FSBS values ranged from 109-373.

Review of Resident #3's May 2024 eMAR from 05/01/24 to 05/14/24 revealed:
-There was an entry for insulin glargine 100 units/ml inject 35 units subcutaneously every morning scheduled at 6:30am.
-There were 7 of 14 opportunities for insulin glargine morning administrations and documented as resident refused.
-There was an entry for insulin glargine 100 units/ml inject 30 units subcutaneously every

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evening scheduled at 8:00pm.
-There were 7 of 13 opportunities for insulin glargine evening administrations and documented as resident refused.
-Resident #3's FSBS values ranged from 102-195.

Review of Resident #3's progress notes revealed there was not documentation the PCP was notified of insulin refusals and missed insulin doses.

Telephone interview with Resident #3's PCP on 05/15/24 at 4:15pm revealed:
-He was not notified of any of Resident #3's insulin refusals in March, April, and May 2024.
-He expected the facility to notify him if Resident #3 refused insulin after 3 consecutive days.
-Resident #3's Hemoglobin A1c laboratory results increased from 6.7% on 01/25/24 to 7.4% on 04/11/24 and that could be due to insulin refusals.

Interview with Resident #3 on 05/15/24 at 3:40pm revealed she sometimes refused her insulin because she did not want to be administered the injections.

Interview with a MA on 05/15/24 at 1:15pm revealed:
-Resident #3 refused insulin often.
-She documented Resident #3 insulin refusals on the eMAR, but she had not let anyone else know about Resident #3's insulin refusals, including the PCP.

Interview with the RCC on 05/15/24 at 1:40pm revealed:
-She did not know about any of Resident #3's insulin refusals.
-She expected MAs to let her know if a resident

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refused insulin 3 times consecutively and she would reach out to the PCP to notify the PCP.

Interview with the Administrator on 05/15/24 at 4:55pm revealed:
-She did not know about any of Resident #3's insulin refusals.
-She expected MAs to let her or the RCC know if a resident refused insulin 3 times consecutively so the PCP could be notified.

2. Review of Resident #5's current FL-2 dated 01/29/24 revealed diagnoses including alcoholism, cirrhosis, anemia, and thrombocytopenia.

Review of a Resident #5's primary care provider (PCP) dated 03/05/24 revealed:
-Resident #5 was sluggish, did not want to get out of bed, and wanted to eat meals in her room.
-Instructions to order an ammonia level, vitamin B12 level, magnesium level, complete metabolic panel (CMP), and a valproic acid level.

Review of Resident #5's record revealed there were no documented results for the laboratory work ordered on 03/05/24.

Interview with Resident #5 on 05/15/24 on 3:10pm revealed she did not know whether she had blood drawn in March 2024.

Interview with Resident #5's PCP on 05/15/24 at 4:15pm revealed:
-He just started seeing residents in the facility in February 2024 and was not aware the laboratory work orered for Resident #5 were not completed.
-The previous PCP wrote the order for Resident #5 on 03/05/24 for laboratory work to be done.
-He was concerned that laboratory work was not

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being done and orders were not being carried out.
-He expected the facility staff to follow through and carry out orders.

Interview with the Resident Care Coordinator (RCC) on 05/15/24 at 1:45pm revealed:
-She went with the PCP when he came to the facility to see residents.
-She reviewed the PCP's notes with the Administrator.
-If the PCP did not write an order for laboratory work, she faxed the progress note to the laboratory and also called the laboratory.
-Routine laboratory work days were on Thursdays.
-She did not know why the ordered laboratory work for Resident #5 did not get done.

Interview with the Administrator on 05/15/24 at 4:45pm revealed:
-She reviewed the progress notes with the RCC when the PCP left the facility.
-She was unaware Resident #5 did not have her laboratory work done as ordered on 03/05/24.
-She expected the physician's orders to be carried out.

____

The facility failed to complete a provider order for a resident referral to pain management (#3) placing the resident at risk for increased pain, failed to notify the primary care provider (PCP) in a timely manner of multiple refusals of basal insulin (#3) placing the resident at risk for elevated blood sugar levels and elevated HgbA1c results, and failed to obtain laboratory work (#5) for a resident with liver cirrhosis placing the resident at risk for change in condition. This failure was detrimental to the health, safety, and

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D 273	Continued From page 9 welfare of the residents and constitutes a Type B Violation. ________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/15/24. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 29, 2024.	D 273		
D 299	10A NCAC 13F .0904(d)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall be based on the U.S. Department of Agriculture Dietary guidelines for Americans 2020-2025, which are hereby incorporated by reference including subsequent amendments and editions. These guidelines can be found at https://dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf for no cost. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that 8 ounces of milk or other equivalent dairy products were served three times daily to residents in the Special Care Unit (SCU). The findings are: Review of the facility's SCU census revealed a	D 299	D 299 pgs. 10-15 13F .0904(a)(3) Inservice were completed with all staff by ED about the requirements of dairy products being served three times a day. Staff were also educated on other items that could be used as a dairy product to meet this requirement. Kitchen staff were also made aware to please inform ED of any needs in this department in a timely manner. ED is currently looking to hire a dietary manager, in the meanwhile it shall be the responsibility of the ED to ensure all dietary requirements are being met.	5/16/24

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census of 16 residents.

Review of the facility's daily menu for 05/14/24 and 05/15/24 revealed:
-Milk was listed to be served for the breakfast, lunch and dinner meal service.
-Assorted snacks and beverages were listed to be served for the morning, mid-day and evening snacks.
-There were no equivalent dairy products listed on the menu to be served on 05/14/24 or 05/15/24.

Observation of the kitchen on 05/14/24 at 2:41pm revealed there were 8 unopened gallons of milk (128 servings) and ¾ of an opened gallon of milk in the reach-in cooler.

Observation of the SCU lunch meal service on 05/14/24 between 12:00pm and 12:45pm revealed:
-There were 15 residents in the SCU dining room with 2 glasses in their place settings and were served water and juice or tea.
-There was an opened gallon of milk, ¾ full on top of the insulated meal tray cart.
-There were no other glasses/cups on top of the insulated meal tray cart or in the SCU dining room.
-The partial gallon of milk was not taken into the SCU dining room and was not offered to SCU residents when they had finished beverages in their 2 glasses.
-There were 15 residents in the SCU dining room who were not served milk and there were no other dairy products offered or served to the 15 residents.

Interview with a personal care aide (PCA) on 05/14/24 at 12:38am revealed:

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-All 15 residents in the dining room during the lunch meal service on 05/14/24 were not served milk because they ran out of glasses.
-Another staff went to get more cups from the kitchen, but had not returned with more cups.
-The kitchen staff usually sent enough glasses on top of the food cart to serve milk to all of the residents for each meal.
-She had not been told to serve the residents any other dairy products.

Interview with a medication aide (MA) on 05/14/24 at 12:39pm revealed:
-The Resident Care Coordinator (RCC) went to the kitchen to pick up more cups, but had not brought any back by the end of the lunch meal.
-The kitchen normally sends extra glasses on the cart for each meal.
-Every resident normally would get milk with each meal, but did not for lunch today because they ran out of glasses.

Interview with a second PCA on 05/14/24 at 12:40pm revealed:
-All residents were not served milk for the breakfast meal service on 05/14/24 because there were not enough glasses for milk.
-Another staff went to the kitchen to get more glasses, but had not returned with them.
-She was not sure why there were not enough glasses to serve milk to the SCU residents.

Observation of the SCU breakfast meal service on 05/15/24 between 7:30am and 7:45am revealed:
-There were 14 residents in the SCU dining room with 3 residents with 3 glasses in their place settings who were served water, juice and milk.
-There were 5 glasses filled with milk on top of the insulated meal tray cart that were not served

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to any residents.
-Staff cleared 6 used glasses/cups on top of the insulated meal tray cart with milk residue.
-There were 11 residents in the SCU dining room who were not served milk at the breakfast meal and there were no other dairy products offered or served.

Interview with a PCA on 05/15/24 at 7:35am revealed:
-She thought all SCU residents in the dining room had been served milk.
-She did not know why there were 5 unserved glasses of milk left on top of the insulated food tray cart.
-She removed glasses as the residents finished their beverages and therefore could not tell for sure which residents had milk.

Interview with a MA on 05/15/24 at 7:40am revealed:
-There were glasses of milk sent on top of the insulated meal tray cart for residents for breakfast.
-She was unsure of the number of milk glasses that were sent by the kitchen.
-She did not pay attention to know if every SCU resident in the dining room got milk with breakfast.

Interview with a kitchen staff on 05/14/24 at 3:50pm revealed:
-Residents were to be served milk, water, and another beverage for breakfast, lunch and dinner meal service.
-She received a food delivery on 04/14/24 and 8 gallons of milk were delivered.
-Milk was not served to all the residents for the lunch meal service on 05/14/24, because there were not enough glasses available.

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-She did not have enough glasses to serve SCU residents 3 beverages for 3 days.
-Residents carried their glasses to their rooms or outside and sometimes glasses were not brought back to the kitchen when residents were served meals in their rooms.
-There was currently no kitchen manager therefore the Administrator was responsible for ordering plateware, but she did not inform the Administrator that she did not have enough glasses until today, 05/14/24 after lunch.

Interview with a second kitchen staff on 05/15/24 at 8:25am revealed:
-She knew every SCU resident was to be served milk, water and another beverage for each meal service.
-She had enough glasses for today's breakfast meal for milk, water and juice for each resident.
-She prepared exactly 16 glasses of milk for the SCU residents for the breakfast meal.
-Each SCU resident should have received a glass of milk for the breakfast meal.

Interview with the Resident Care Coordinator (RCC) on 05/14/24 at 3:30pm revealed:
-She thought the residents needed to be served milk 2 times a day with meals.
-She did not know until today's lunch meal that there were not enough glasses for SCU residents to be served milk along with water and another beverage.
-She inquired about glasses to the kitchen staff and was told there had been a shortage of glasses for 2 days.
-She expected staff to serve milk to the residents at every meal according to the menu and regulations.

Interview with the Administrator on 05/15/24 at

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D 299	Continued From page 14 11:20am revealed: -She was not aware there were not enough glasses for 3 days for all residents to be served milk, water and another beverage with each meal until yesterday after the lunch meal on 05/14/24. -If she had been informed, she would have purchased more glasses as she did yesterday evening on 05/14/24. -She expected milk or an equivalent dairy substitution to be served to all residents with each meal.	D 299	D310 pgs. 15-19 13F .0904(e) ED completed an in-service with kitchen staff about following orders as they are written and if they have any questions about an order to please ask the RCC'S, never change an order on their own. This will be monitored by RCC's and ED until Dietary Manager is hired.	5/16/24
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, interviews and record reviews the facility failed to serve a therapeutic diet as ordered for 1 of 5 sampled residents (#4) who had an order for a mechanical soft chopped diet. The findings are: 1. Review of Resident #4's current FL2 dated 06/27/23 revealed diagnoses included dementia and schizophrenia disorder. Review of Resident #4's diet orders dated 02/05/24 revealed an order for a mechanical soft chopped diet. Review of a signed physician's order for Resident	D 310		

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#4 dated 02/05/24 revealed there was an order for a mechanical soft chopped diet.

Review of the facility's therapeutic diet list posted in the kitchen updated 09/25/23 revealed Resident #4 was to be served a mechanical soft chopped diet.

Interview with a kitchen staff on 05/14/24 at 10:50 revealed:
-There was no Dietary Manager (DM) at that time, so she and the other staff were running the kitchen and preparing meals according to their experience.
-The food truck delivery was due this morning but was delayed and would not be there before lunch.
-She had to substitute lunch today and had to prepare bar-b-que (BBQ) ribs, macaroni and cheese, mixed vegetables and pudding instead of the listed menu.

Review of the therapeutic menu spreadsheet for the lunch meal service on 05/14/24 revealed meat was to be chopped to bite-size pieces for any meat served.

Observation of Resident #4's lunch meal service on 05/14/24 between 12:00pm and 12:45pm revealed:
-Resident #4 was served 2 bar-b-que (BBQ) ribs that were 4 inches by 2 inches, macaroni and cheese, diced mixed cooked vegetables, banana pudding and a roll.
-Resident #4 attempted to raise a BBQ rib to her mouth but was not able to take a bite.
-A PCA cut Resident #4's BBQ ribs in bite-size pieces after she was asked about her diet orders.
-Resident #4 consumed 50% of the meal without any difficulty after the BBQ ribs were cut.

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Observation of the Special Care Unit (SCU) dining room on 05/14/24 revealed:
-There was a therapeutic diet list posted on the wall.
-Resident #4 was listed to receive a mechanical soft chopped diet.

Interview with a personal care aide (PCA) on 05/014/24 at 12:20pm revealed:
-Resident #4 was on the list to have a mechanical soft chopped diet.
-Resident #4 was supposed to have mechanical soft with chopped meat diet.
-She looked at the meals before she served them to residents to make sure they were correct.
-She had not noticed that Resident #4's meat was not chopped until she was asked about the diet.
-She chopped Resident #4's ribs when she realized her meat was not chopped.

Interview with the cook on 05/14/24 at 3:50pm revealed:
-She knew Resident #4 had an order for a mechanical soft chopped diet.
-Her diet order meant that her meat had to be chopped and all other food had to be soft.
-She usually chopped her meat into pieces about 1 inch or so.
-She served Resident #4's BBQ ribs whole because they were tender, so she thought she did not need to chop them into bite-size pieces.

Telephone interview with Resident #4's family member on 05/15/24 at 9:28am revealed:
-She was not aware Resident #4 was ordered a chopped diet.
-She brought Resident #4 home with her on occasion and had always served her meats whole, such as hamburgers and chicken.
-Resident #4 never appeared to have difficulty

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eating the meats whole and she never chopped her meat at home.
-Resident #4 did not have trouble swallowing and did not have a reason to have a swallowing study for her diet recommendation.

Telephone interview with the facility's Registered Dietitian (RD) on 05/15/24 at 11:06am revealed:
-She approved the facility's therapeutic diet menus provided by the facility's food supplier.
-Resident #4's mechanical soft chopped diet meant she was to have easy to chew fork tender foods and her meats had to be chopped into bite-size pieces even if the meat were tender.
-This type of diet was usually meant for residents who could chew and swallow without difficulty but made it more convenient or easier for them to feed themselves.

Telephone interview with Resident #4's primary care provider (PCP) on 05/15/24 at 4:40pm revealed:
-Resident #4 had a current order for a mechanical soft chopped diet.
-Review of the previous PCP 's notes indicated that Resident #4's diet order was due to her not opening her mouth wide enough to bite large pieces of meat.
-Resident #4 did not have any swallowing difficulty or aspiration risk.
-If the meat was tender, there was no danger to her for any reason.
-He expected the facility to serve Resident #4 meals according to the mechanical soft chopped diet menu.

Based on observations, record reviews and interviews, it was determined Resident #4 was not interviewable.

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D 310	Continued From page 18 Interview with the Resident Care Coordinator (RCC) on 05/14/24 at 3:30pm revealed: -Resident had an order for a mechanical soft chopped diet. -Resident #4 did not have any difficulty chewing or swallowing. -Her diet order reflected the fact that she did not open her mouth wide and the PCP wanted to make it easier for her to feed herself. -She expected staff to serve Resident #4 a mechanical soft chopped diet as ordered by the PCP. Interview with the Administrator on 05/15/24 at 11:20am revealed: -There was no DM at that time, staff were cooking/serving as they normally did. -The kitchen staff should serve chopped food as ordered even if the food was tender. -She expected all staff to serve residents their meals according to their current diet order by the PCP.	D 310	D 358 pgs. 19-27 13F .1004 (a) Med Techs and RCC's were in-serviced by RN about notification of any missed meds being completed to PCP and RCC''s during each miss med, refusals after 3. Continuing education will be provided to all med techs by RCC's on a weekly basis. Steps to follow when medication runs out was provided to med techs and posted in med room. D358 pgs. 27-30 13F .1004 (a) ED educated all med techs and RCC's about checking every draw on the cart for missing medication, once all possible places were searched then they need to contact RCC's and Pharmacy. In-service was also provided to all med techs to inform PCP and RCC's anytime a medication is not given to a resident whether its due to a refusal or medication not available. RCC's will inform ED of any missed medications. To prevent this from occurring again RCC's will be conducting their own weekly cart audit in addition to what the lead SIC does weekly. ED and RCC's will discuss audits weekly.	5/22/24
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: TYPE B VIOLATION	D 358		

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Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents (#5 and #3) related to eyedrops for glaucoma (#5) and an antidepressant (#3).

The findings are:

1. Review of Resident #5's current FL-2 dated 01/29/24 revealed diagnoses of alcoholism, cirrhosis, anemia, and thrombocytopenia.

Review of Resident #5's current FL-2 dated 01/29/24 revealed an order for timolol maleate 0.5% eye drops (used to treat glaucoma) one drop into each eye at bedtime.

Review of Resident #5's March 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for timolol maleate 0.5% eye drops instill one drop in each eye at bedtime scheduled at 7:00pm.
-Timolol maleate 0.5% eye drops were documented as administered from 03/02/24 to 03/08/24, 03/12/24 to 03/22/24, and from 03/24/24 to 03/31/24.
-Timolol maleate 0.5% eye drops were documented as refused on 03/10/24, 03/11/24 and 03/23/24.
-There was no documentation timolol maleate 0.5% eye drops were administered on 03/01/24 and 03/09/24.

Review of Resident #5's April 2024 eMAR revealed:
-There was an entry for timolol maleate 0.5% eye drops instill one drop in each eye at bedtime scheduled at 7:00pm.
-Timolol maleate 0.5% eye drops was

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documented as administered from 04/01/24 to 04/18/24, and 04/22/24 to 04/30/24.
-Timolol maleate 0.5% eye drops were documented as refused on 04/20/24 and 04/21/24.
-There was no documentation timolol maleate 0.5% eye drops were administered on 04/19/24.

Review of Resident #5's 05/01/24 to 05/13/24 eMAR revealed:
-There was an entry for timolol maleate 0.5% eye drops instill one drop in each eye at bedtime scheduled at 7:00pm.
-Timolol maleate 0.5% eye drops were documented as administered from 05/01/24 to 05/13/24.

Observation of Resident #5's medications on hand on 05/15/24 at 9:45am revealed:
-There was a bottle of timolol maleate 0.5% eye drops with a dispensed date of 04/21/24.
-The bottle of timolol maleate 0.5% eye drops was opened on 04/21/24.

Telephone nterview with a pharmacist from the facility's contracted pharmacy on 05/15/24 at 10:52am revealed:
-Resident #5 had an order for timolol maleate 0.5% eye drops instill one drop in each eye at bedtime dated 01/21/24.
-A 5ml bottle of timolol maleate 0.5% eye drops was dispensed on 02/01/24 and 04/20/24.
-A 5ml bottle of timolol maleate 0.5% eye drops would last 28 days after opening.
-Timolol maleate eye drops were used to treat glaucoma.
-If timolol maleate eye drops were not administered as ordered, the resident could experience vision problems and increased intraocular pressure.

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b. Review of Resident #5's current FL-2 dated 01/29/24 revealed there was an order for rhopressa 0.02% eye drops (used to treat glaucoma) one drop into each eye at bedtime.

Review of Resident #5's March 2024 eMAR revealed:
-There was an entry for rhopressa 0.02% eye drops instill one drop into each eye at bedtime with a scheduled administration time of 7:00pm.
-Rhopressa 0.02% eye drops were documented as administered from 03/02/24 to 03/08/24, 03/12/24 to 03/22/24, and 03/24/24 to 03/31/24.
-Rhopressa 0.02% eye drops were documented as refused on 03/10/24 and 03/23/24.
-Rhopressa 0.02% eye drops were documented as not administered on 03/11/24 due to Resident #5 being in the hospital.
-There was no documentation rhopressa 0.02% eye drops were administered on 03/01/24.

Review of Resident #5's April 2024 eMAR revealed:
-There was an entry for rhopressa 0.02% eye drops instill one drop into each eye at bedtime with a scheduled administration time of 7:00pm.
-Rhopressa 0.02% eye drops were documented as administered from 04/01/24 to 04/04/24, 04/11/24 to 04/18/24, and from 04/20/24 to 04/30/24.
-Rhopressa 0.02% eye drops were documented as not administered from 04/05/24 to 04/10/24 due to the medication being on order from the pharmacy.
-There was no documentation rhopressa 0.02% eye drops were administered on 04/19/24.

Review of Resident #5's 05/01/24 to 05/13/24 eMAR revealed:

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-There was an entry for rhopressa 0.02% eye drops instill one drop into each eye at bedtime with a scheduled administration time of 7:00pm.
-Rhopressa 0.02% eye drops were documented as administered from 05/01/24 to 05/05/24, 05/07/24, 05/08/24, and from 05/10/24 to 05/13/24.
-Rhopressa 0.02% eye drops were not administered on 05/06/24 and 05/09/24 due to being on order from the pharmacy and waiting on arrival.

Observation of Resident #5's medications on hand on 05/15/24 at 9:30am revealed:
-There was an empty 2.5ml bottle of rhopressa 0.02% eye drops on the medication cart.
-The bottle had an opened date of 04/09/24.
-There was a unopened 2.5ml bottle of rhopressa 0.02% eye drops in the refrigerator in the medication room with a dispensed date of 05/08/24.

Interview with a pharmacist from the facility's contracted pharmacy on 05/15/24 at 10:52am revealed:
-Resident #5 had an order for rhopressa 0.02% eye drops instill one drop into each eye at bedtime dated 01/21/24.
-A 2.5ml bottle of rhopressa 0.02% eye drops was dispensed on 02/02/24, 04/08/24, and 05/07/24.
-The rhopressa eye drops should have been ordered in March 2024.
-The bottle of rhopressa eye drops dispensed on 04/08/24 would have been expired if opened when received.
-Rhopressa eye drops should be refrigerated until opened and they expired 28 days after opening.
-Rhopressa eye drops were used to treat glaucoma.
- If rhopressa eye drops were not administered as

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ordered, the resident could experience vision problems and increased intraocular pressure.

c. Review of Resident #5's current FL-2 dated 01/29/24 revealed there was an order for travapost 0.004% eye drops (used to treat glaucoma) one drop into each eye at bedtime.

Review of Resident #5's April eMAR revealed:
-There was an entry for latanoprost 0.005% eye drops instill one drop to both eyes at bedtime with a scheduled administration time of 8:00pm.
-Latanoprost 0.005 eye drops were documented as administered on 04/22/24, 04/23/24, and from 04/26/24 to 04/30/24.
-Latanoprost 0.005% eye drops were documented as not administered on 04/18/24, 04/20/24, 04/21/24, and from 04/24/24 to 04/27/24 due to being unavailable.
-There was no documentation latanoprost 0.005% eye drops were administer on 04/19/24.

Review of Resident #5's 05/01/25 to 05/13/24 revealed:
-There was an entry for latanoprost 0.005% eye drops instill one drop in each eye at bedtime dated 04/17/24.
-Latanoprost 0.005% eye drops were documented at administered from 05/01/24 to 05/13/24.

Observation of Resident #5's medications on hand on 05/15/24 at 9:30am revealed:
-There was an opened bottle of a 2.5ml bottle of latanoprost 0.005% eye drops available for administration.
-The date opened sticker was covered by another label and could not be read.

Telephone interview with a pharmacist from the

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facility's contracted pharmacy on 05/15/24 at 10:52am revealed:
-There was an order for latanoprost 0.005% eye drops instill one drop in both eyes at bedtime dated 04/17/24.
-A 2.5ml bottle of latanoprost 0.005% eye drops was dispensed on 04/17/24.

Refer to interview with Resident #5 on 05/15/24 at 3:10pm.

Refer to interview with Resident #5's Primary Care Provider (PCP) on 05/15/24 at 4:15pm.

Refer to interview with Resident #5's ophthalmologist on 05/15/24 at 10:30am.

Refer to interview with a medication aide (MA) on 05/15/24 at 1:15pm.

Refer to interview with the Resident Care Coordinator (RCC) on 05/15/24 at 1:45pm.

Refer to interview with the Administrator on 05/15/24 at 4:40pm.

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Interview with Resident #5 on 05/15/24 at 3:10pm revealed:
-She had glaucoma.
-Her vision was okay but she wished it could be better.
-She did get eye drops sometimes but was not sure how often she was supposed to get them.
-She did not have any eye pain or headaches.

Telephone interview with Resident #3's primary care provider (PCP) on 05/15/24 at 4:13pm revealed:
-He did not know Resident #5 was not

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	HAL093010	A. BUILDING: ______ B. WING ______	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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administered her eye drops as ordered for her glaucoma.
-Eye drops for glaucoma were needed to keep pressure down and prevent other complications such as decreased or loss of vision, headaches, and blurred vision.
-He expected Resident #5 to have been administered her medications as ordered by the provider.

Telephone interview with Resident #5's ophthalmologist on 05/15/24 at 10:30am revealed:
-Resident #5 had glaucoma and was prescribed eye drops to keep intraocular pressure down.
-Resident #5 received the eye drops from the facility's contracted pharmacy.
-It was important for Resident #5 to receive the eye drops as ordered to prevent intraocular pressure from rising and other vision problems that included decreased vision, headaches, and vision loss.

Telephone interview with a MA on 05/15/24 at 1:15pm revealed:
-She administered Resident #5's eye drops as ordered.
-Resident #5 did not refuse her eye drops.
-If the eye drops were not available on the medication cart, she looked in the refrigerator to see if they were there.
-If she could not locate the eye drops, she documented on the eMAR that the medications were not in the facility.
-She was also supposed to call the pharmacy and request the medication but she did not always do that.
-The RCC was also supposed to be made aware but there was currently not a RCC on the assisted living unit and she did not let the RCC on the

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Special Care Unit (SCU) know either.
-The eye drops had to be reordered by the facility MAs, the pharmacy did not automatically send them.

Interview with the RCC on 05/15/24 at 1:45pm revealed:
-She was the RCC for the SCU and had started working on the Assisted Living (AL) unit two days prior on 05/13/24.
-She did not know Resident #5 had not received her prescribed eye drops as ordered.
-MAs were supposed to let the RCC know when a medication was not available.
-She did not know why the pharmacy dispensed the latanoprost 0.005% on 04/17/24 but the MA's were documenting that they were not available.

Interview with the Administrator on 05/15/24 at 4:55pm revealed:
-She was not aware Resident #5 was not administered her eye drops as ordered,
-She expected MAs to administer medications as ordered and let the RCC know if the medications were not available.

2. Review of Resident #3's current FL-2 dated 01/29/24 revealed:
-Diagnoses included type 2 diabetes and bipolar mood.
-There was an order for duloxetine (used to treat depression) 60mg capsule take one capsule daily.

Review of Resident #3's April 2024 electronic medication administration record (eMAR) revealed:

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-There was an entry for duloxetine 60mg take 1 capsule every morning scheduled at 8:00am.
-There was documentation duloxetine was not administered from 04/19/24 to 04/21/24 and from 04/24/24 to 04/27/24 with the reason documented as the medication was not available to be administered.

Review of Resident #3's May 2024 eMAR from 05/01/24 to 05/14/24 revealed:
-There was an entry for duloxetine 60mg take 1 capsule every morning scheduled at 8:00am.
-There was documentation duloxetine was not administered from 05/03/24 to 05/14/24 with the reason documented as the medication was not available to be administered.

Observation of Resident #3's medications on hand on 05/15/24 at 10:20am revealed there was one duloxetine 60mg medication card with a dispensed date of 05/11/24 available for administration with 29 of 30 capsules remaining.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/15/24 at 10:55am revealed:
-There was an active order on file for Resident #3 for duloxetine 60mg capsule take one capsule daily.
-The pharmacy dispensed duloxetine 60mg for Resident #3 on 03/19/24, 04/19/24 and 05/11/24 for a quantity of 30 capsules which was a 30-day supply.
-The facility requested a duloxetine re-order on 05/07/24, 05/08/24 and 05/09/24, but insurance rejected the re-order request because it was too soon to dispense more medication.

Telephone interview with a medication aide (MA) on 05/15/24 at 4:06pm revealed:

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-She documented on Resident #3's eMAR that duloxetine was not available to be administered from 05/03/24 to 05/05/24, 05/07/24, 05/08/24, 05/10/24 and 05/14/24.
-The duloxetine was not on the medication cart on those days and she thought the duloxetine medication card was lost.

Telephone interview with Resident #3's primary care provider (PCP) on 05/15/24 at 4:13pm revealed:
-He did not know Resident #3 was not administered duloxetine for 7 days in April 2024 and for 12 consecutive days in May 2024.
-He expected Resident #3 to have been administered duloxetine as ordered.
-Potential side effects of missing 12 consecutive days of duloxetine 60mg administration included dizziness, disorientation, and increased fall risk.

Interview with Resident #3 on 05/15/24 at 3:40pm revealed:
-She did not know if she had missed any doses of her duloxetine.
-She had not felt dizzy or disoriented recently.

Interview with the Resident Care Coordinator (RCC) on 05/15/24 at 1:45pm revealed:
-She did not know Resident #3 was not administered duloxetine for 7 days in April 2024 and for 12 consecutive days in May 2024.
-She expected MAs to let her know if a resident's medication was missing or not available because she could help the MAs find the medication or reorder it.

Interview with the Administrator on 05/15/24 at 4:55pm revealed:
-She did not know Resident #3 was not administered duloxetine for 7 days in April 2024

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and for 12 consecutive days in May 2024 prior to 05/14/24.
-She found Resident #3's missing duloxetine medication card dated 04/19/24 in the medication overflow cart on 05/14/24.
-The MAs did not know Resident #3's duloxetine was in the medication overflow cart and available to be administered in the facility when it was not administered.
-Resident #3's duloxetine was dispensed on time and should have been administered.
-She expected MAs to administer medications as ordered.

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The facility failed to ensure medications were administered as ordered for Resident #5 who was not administered eyedrops for treatment of glaucoma to maintain intraocular pressure placing the resident at risk for worsening eyesight and potential blindness long term (#5), and for Resident #3 who was not administered an antidepressant for 12 consecutive days placing the resident at risk for dizziness, disorientation and increased fall risk. This failure was detrimental to the health and safety of the residents and constitutes a Type B Violation.

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The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/15/24 for this violation.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED June 29, 2024.