STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	06/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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) COMPLETION DATE
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to ensure walls were in repair for 3 of 3 halls (room #109, 105, 102, 100, 101, 208, 309, 104) that had torn wall paper and holes in the sheetrock. The findings included: Observation on 06/15/15 at 8:35am revealed room #104 to have a visible sheet rock beihind bed A. The sheet rock was concave in shape. To the left of bed A was an electrical socket. A hole in the sheet rock was observed directly underneath the electrical socket. Further observation of Room #104 revealed a large hole behind bed B with torn wallpaper. The sheet rock was observed to have a large hole directly though the sheet rock. Observation of Room #100 at 12:15am revealed a hole behind the bed. At 3:45pm room # 101, 102, 105, 109, 208, and 309 were also observed to have holes behind residents' beds. Observation of the facility maintenance log from 4/1/15 through 6/16/15 revealed no maintenance requests in regards to holes in walls or missing sheet rock. During an interview and observation with maintenance on 6/16/15 at 3:15pm revealed he	F 253	Rooms 101, 102, 105, 109, 208 and 309 have been repaired by Maintenance Department on 07/08/15. All holes in sheetrock have been replaced or patched. A 100% audit of all rooms was completed by Maintenance Director on 06/25/15 to identify any repairs that was needed to each room. A list was complied by the Maintenance Director on 06/25/15 of his findings. Eight other rooms were identified with holes in the sheetrock. Maintenance Director has scheduled these rooms to be repaired in order of importance. Staff was educated by Administrator on 07/09/15 on filling out maintenance requests when items are found in resident rooms or common areas needing to be repaired. Maintenance Director will educate all new hires on proper procedure of filling out maintenance request and were to place them during new hire orientation. Weekly audits will be performed by department heads during guardian angel rounds 3 times a week for four weeks then monthly times four months to identify any new maintenance repairs needed. Guardian angel round sheets will be utilized and the department head will fill out repair requisitions as needed for	7/10/15

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

Electronically Signed | 07/09/2015

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F 253	Continued From page 1 was aware there were some issues with wallpaper tearing but he was unaware of the hole in the walls in room #104 were as bad as observed. He stated he was notified of items in the facility that were in need of repair by staff. Staff were to document the concern on a maintenance request form and put the request in a central location. Maintenance indicated he checked the maintenance log daily and more often in the instance he notices there are requests in his box. Maintenance revealed the facility was going through renovations but they were halted. Maintenance stated he assumed the holes were being created by staff pushing beds up against the wall or staff lowering or raising beds. Interview with Nursing Assistant #1 (NA) on 6/17/15 at 11:45am revealed she was aware that there were holes behind some of the resident ' s beds. The NA#1 stated she had communicated the concern to nursing verbally. Interview with Nurse #4 on 6/17/15 at 11:47am revealed she was aware of holes behind some resident beds. Nurse #4 stated she had communicated the concern to the maintenance department. The Nurse indicated she did not write the maintenance request down on a maintenance request form. Nurse #4 stated she communicated the concern verbally to maintenance. Interview with housekeeping staff/floor technician on 6/17/15 at 11:53am revealed he was aware of the holes in walls in resident rooms. The floor technician stated that the holes were created when staff move the resident beds against the wall or move resident beds up or down. The bed	F 253	findings. These results will be brought into monthly QA meeting and reviewed.	

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F 253	Continued From page 2 eventually digs into the wall until it creates a hole. During an interview and observation with the Administrator on 6/16/15 at 3:30pm revealed he was unaware of the holes in the walls. The Administrator indicated the facility's previous renovations were halted. The Administrator indicated that although renovations were halted his expectation was that holes in the sheetrock be repaired. The Administrator further indicated he expected his staff to communicate maintenance concerns by utilizing the maintenance request forms.	F 253		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to be free of a medication error rate greater than 5% as evidenced by 2 medication errors out of 26 opportunities, resulting in a medication error rate of 7.6%, for 2 of 5 residents (Resident #18 and Resident #11) observed during medication pass. The findings included: 1) On 6/16/15 at 4:10 PM, Nurse #1 was observed as she prepared and administered medications to Resident #18. The administered medications included two-Creon Delayed Release (DR) 24,000 Unit capsules. Creon DR is a	F 332	Resident #18 and Resident #11 were reviewed by Medical Director on 06/23/15 due to recent medication errors. No harmful effects were noted. Resident #18 discharged from the facility on 07/01/15. Medication error reports were completed by Director of Nursing on 06/23/15. 100% of Medication administration records were audited by Unit Manager on 06/23/15 to identify any resident with an order for medications to be given with food or at mealtime. 16 residents were found to have such orders. MD also reviewed the orders on 06/23/15 of those residents identified to ensure that the	7/10/15

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F 332	Continued From page 3 medication which contains a combination of digestive enzymes that act locally in the small intestine to aid in the digestion of fats, protein, and starches. Creon is used to replace these enzymes when the body does not have enough of its own. Product information from the manufacturer indicated because of the local action of this medication, Creon must be taken with food to work. A review of Resident #18 ' s June 2015 physician ' s medication orders included a current order for Creon DR 24,000 Unit capsules to be given as two capsules by mouth with meals. The Creon DR was scheduled for administration three times daily at 8:00 AM, 12:00 PM, and 5:00 PM. An interview was conducted on 6/16/2015 at 5:10 PM with Nurse #1. During the interview, Nurse #1 reviewed Resident #18 ' s Medication Administration Record (MAR), along with the physician ' s order to give Creon with meals. Nurse #1 stated she thought it was okay to give the Creon because she administered the medication with some pudding (½ - 1 ounce) and a nutritional supplement (90 milliliters or 3 ounces). At the time of the interview, Resident #18 had not yet received her evening meal tray. An observation made on 6/16/15 at 5:20 PM revealed the meal trays had not yet been delivered to Resident #18 ' s hallway. A review of the facility ' s meal schedule revealed evening meal trays were scheduled to be sent to her hallway at 5:30 PM. A review of the meal intake record for Resident #18 revealed the resident consumed 100% of her evening meal on 6/16/15.	F 332	instructions were clear and precise on how the medication should be given and individually re-educated by Director of Nursing on 06/23/15 for medication errors and proper instruction on 5 rights of medication administration. All other licensed nurses were educated on 06/29/15 by Holladay pharmacy consultant on medication administration and pharmacy policy and procedures concerning 5 rights of medication administration. New hired licensed nurses will be educated on same information during the orientation process by the Director of Nursing or Unit Manager. Medication administration audits will be performed by observing medication pass by Director of Nursing and/or Unit Manager two times a week for four weeks and then monthly for four months. These results will be brought into monthly QA meeting and reviewed.	

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F 332	Continued From page 4 An interview was conducted on 6/17/15 at 9:14 AM with the facility ' s Director of Nursing (DON) and Consultant Nurse. During the interview, the DON indicated if the physician ' s order was for the Creon to be given with meals, then it should be given with a meal. A telephone interview was conducted on 6/17/2015 at 11:43 AM with the facility ' s consultant pharmacist. Upon review of the timing observed for the Creon DR administration to Resident #18 relative to the scheduled evening meal service on 6/16/15, the pharmacist stated that the medication probably would have gone through her before the food (from the evening meal) got to her. The pharmacist stated this timing was, "clinically indefensible." 2) On 6/17/15 at 8:30 AM, Nurse #3 was observed as she prepared and administered medications to Resident #11. The medications pulled for administration included one -100 milligram (mg) capsule of docusate (a stool softener). A review of Resident #11 ' s June 2015 physician ' s medication orders included a current order for 100 mg docusate capsules to be given as two capsules by mouth twice daily. An interview was conducted on 6/17/15 at 8:30 AM with Nurse #3. During the interview, Nurse #3 reviewed Resident #11 ' s Medication Administration Record (MAR), which revealed two capsules of 100 mg docusate were ordered for administration to Resident #11 at 8:00 AM. Upon review of the order, Nurse #3 stated she missed seeing the order for two capsules and would need	F 332		

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F 332	Continued From page 5 to give Resident #11 one additional capsule of 100 mg docusate. The nurse attributed this medication error to being nervous during the medication pass observation. An interview was conducted on 6/17/15 at 9:14 AM with the facility ' s Director of Nursing (DON) and Consultant Nurse. During the interview, the DON indicated his expectation was for the nurses to read the MAR and follow the " five rights " of medication administration (referring to the right patient, the right drug, the right dose, the right route, and the right time).	F 332		