STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING ______ B. WING ______	C 04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA LANE NURSING AND REHABILITATION CENTER	107 MAGNOLIA DRIVE MORGANTON, NC 28655

(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 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and Medical Doctor interview the facility failed to prevent a significant medication error by failing to administer Flagyl (antiparasitic) for 5 days for a Clostridium difficile (Cdiff) infection (Resident #1) and Lactulose (colonic acidifier) for renal insufficiency (Resident #3) for 2 of 3 residents sampled for assuring the facility was free of medication errors. The findings included: 1. Resident #1 was admitted to the facility on 02/13/19 from home under hospice respite care and discharged from the facility on 02/18/19. Resident #1's diagnoses included Clostridium difficile (Cdiff), heart failure, chronic kidney disease, diabetes mellitus and others. No minimum data set (MDS) information was available for Resident #1. Review of a medication list provided by the hospice provider for Resident #1 that contained no date read in part, Resident #1's current medications included: · Amiodarone 200 milligrams (mg) by mouth every day · Ativan 0.5 mg by mouth every 4 hours as needed. · Clotrimazole 1% apply 2 times a day	F 760	Magnolia Lane Nursing and Rehabilitation acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance. Magnolia Lane Nursing and Rehabilitation response to this statement of deficiencies does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Magnolia Lane reserves the right to refute any of the deficiencies on this statement of deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding. F760 How corrective action will be accomplished for these residents found to have been affected by the deficient practice On 2/18/19, resident #1 was discharged	5/2/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/26/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 760	Continued From page 1 · Duloxetine 30 mg by mouth every day · DuoNeb 0.5/2.5mg inhaled 2 times a day · Eliquis 5 mg by mouth give half tablet 2 times a day · Famotidine 20 mg by mouth every day · Glimepiride 1 mg by mouth every day · Hydrocodone/Acetaminophen 7.5/325 mg by mouth every 4 as needed for pain · Isosorbide Mononitrate 30 mg by mouth every day · Lactulose 10 gm/15 milliliters (ml) give 30 ml every day as needed for constipation · Lasix 40 mg by mouth every day · Meclizine 25 mg by mouth every day as needed for dizziness or nausea · Nitroglycerin 0.4 mg by mouth sublingually every 5 minutes as needed · Tizanidine 2 mg by mouth every 8 hours · Tylenol 325 mg by mouth every 8 hours Review of Resident #1's Medication Administration Record dated 02/13/19 revealed that each mediation was administered as stated on the medication list provided by Hospice. Review of a nurses note dated 02/13/19 read in part, received a call from the Hospice Nurse (HN) who gave report on Resident #1. The HN stated that Resident #1 was being treated for suspected Cdiff and was on Flagyl 250 mg by mouth 2 times a day. The note was signed by Nurse #1. Review of a Hospice Note dated 02/13/19 at 2:30 PM read, called facility to give report on Resident #1. Spoke to Nurse #1 who stated that Resident #1 had just arrived at the facility. Report given to Nurse #1 including that Resident #1 was being treated for Cdiff. Reviewed care needed including dressing changes and medications reviewed. The	F 760	from the facility. On 04/04/19 the Director od Nursing (DON) obtained a clarification order from physician on lactulose for resident #3. On 4/18/19 the DON began re-education with all nurses and medication aides on, On all new admissions, medications will be written out per discharge medication list, all orders verified by NP/MD and two nurses to check each MAR. How the facility will identify other residents having the potential to be affected by the same deficient practice On 04/22/19, the DON completed a 100% MAR to cart audit, to ensure availability. The audit revealed no negative findings. On 04/18/19, the DON and Assistant Director of Nurses (ADON) initiated re-educated to all nurses regarding new admission medication orders: On all new admissions, medications will be written out per discharge medication list, all orders verified by NP/MD and two nurses to check each MAR. DON and ADON to re-educate all nurses on this topic on or before 05/02/19. No nurse will be able to work after this date until education is completed. This education will be included in the new nurse orientation. What measures will be put into place or systemic changes made to ensure the	

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F 760	Continued From page 2 note was signed by the HN. An interview was conducted with the HN on 04/04/19 at 10:59 AM. The HN stated that she had assisted Resident #1 and his family with the admission process to the facility for respite care for 5 days in February 2019. She stated that the Social Worker (SW) at the Hospice facility faxed over a current medication list to the facility prior to Resident #1's arrival. She added that she had assisted Resident #1's family with obtaining and preparing his medication to bring to the facility when Resident #1 admitted. The HN stated that the day prior to Resident #1's admission to the facility he was started on Flagyl for a suspected Cdiff infection and when she called the facility on 02/13/19 and spoke to Nurse #1, she informed her of the Flagyl order and the dosage that had been prescribed. The HN stated that she was unaware that the Flagyl was not on the medication list that had been faxed to the facility prior to Resident #1's admission but she had informed Nurse #1 of the order and need for the Flagyl during her telephone report on 02/13/19 at 2:30 PM. The HN stated that she would expect the Flagyl to be given as reported to Nurse #1 during his stay at the facility. An interview was conducted with Nurse #1 on 04/04/19 at 11:48 AM. Nurse #1 explained that she was the wound nurse for the facility, but she also helped the other nurses out as needed. Nurse #1 explained that on 02/13/19 she took report from the HN about Resident #1. She stated that the HN informed her that Resident #1 was coming from home for respite care. Nurse #1 stated that the HN also informed her that Resident #1 had several wounds and was on Flagyl for a Cdiff infection. She added that the	F 760	deficient practice will not recur On 04/12/19 The DON was re-inserviced by the facility Pharmacist on procedure to acquire medications, best practices to safely administer medications and use of the audit tool to monitor medication administration practices. The DON and ADON initiated re-education on 4/4/19 to the nurses, regarding the Pharmacy Policy for re-ordering medications. The re-education provided was, when a medication in not available, obtain medication from E-kit and notify pharmacy to send replacement medication. If medication is not in the E-kit and the pharmacy is unable to send the medication timely, have the pharmacy send the medication to the back-up pharmacy for local pickup. Notify MD/NP. All nurses will be educated on the pharmacy policy and no nurse will be allowed to work after 5/02/19 if education is not completed. This policy will be included in the new nurse orientation and the pharmacy policy will be posted in the front of the Medication Administration Record (MAR) for the nurse to review when needed. On 04/18/19 the DON and ADON re-education was initiated to all nurses regarding new admission medication orders: On all new admissions, medications will be written out per discharge medication list, all orders verified by NP/MD and two nurses to check each MAR. It is the nurse□s responsibility to obtain a thorough report	

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F 760	Continued From page 3 Director of Nursing (DON) had completed the MAR and she assumed the DON had added the Flagyl to the MAR. Nurse #1 confirmed that she did not follow up to make sure the Flagyl orders were on the MAR for administration. She added that she should have followed up with the DON and if the was a discrepancy with the medication list that did not contain the Flagyl she should have contacted the Medical Doctor (MD) for further orders. An interview was conducted with the DON on 04/04/19 at 2:59 PM. The DON stated that after Resident #1 had discharged home on 02/18/19 his family called and asked why the bottle of Flagyl that they had brought to the facility had not been opened or administered. The DON stated that the Flagyl was not listed on the current medication list that was provided to the facility prior to Resident #1's admission on 02/13/19 and that was why they had not given the Flagyl. The DON stated that they administered the medications that were on the list provided and were unable to take orders from the HN. However, the DON added that if there was a discrepancy in the medication list that did not contain the Flagyl that was reported by the HN to Nurse #1 then she would expect Nurse #1 to contact the MD or Hospice staff for clarification of the order. The DON confirmed that Resident #1 had not received the Flagyl while in the facility. An interview was conducted with the MD on 04/04/19 at 3:25 PM. The MD stated that it was concerning and significant that Resident #1 did not receive the Flagyl for a suspected Cdiff infection while in the facility. The MD stated, he would place 80% of the blame on the Hospice organization for failing to send a correct	F 760	from the discharge nurse and clarify any discrepancies. If there are questions/concerns that you aren�t able to address, please notify the DON immediately. All nurses will be re-educated on this topic on or before 05/02/19 and no nurse will be able to work after this date until education is completed. This education will be included in the new nurse orientation. 4/26/19 ADON in serviced on order accuracy and medication availability. How the facility plans to monitor its performance to make sure solutions are sustained DON/ADON will review new admission orders for MD/NP verification of orders, and medication(s) are available in the medication/treatment cart 3 times per week x 4 weeks, then weekly x 8 weeks. Medication pass observations will be completed 3 times per week times 4 weeks then weekly times 8 weeks DON and ADON will be responsible for ensuring re-education and completion of audits. The Director of Nursing will be responsible for substantial compliance. DON will report findings of audits for ongoing discussion during interdisciplinary team meeting as well as report findings to monthly QAPI meeting times 3 months or	

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F 760	Continued From page 4 medication list. He added that the facility staff should have followed up and obtained the correct order and the medication given as ordered. 2. Review of the medical record revealed Resident #3 was admitted to the facility on 3/22/19 with diagnoses including renal insufficiency. Resident #3 had a physician order dated 02/11/19 that read, Lactulose 10 grams (gm) per 15 milliliters (ml) give 15 ml by mouth 2 times a day. An observation of Medication Aide (MA) #1 preparing Resident #3's medication was made on 04/04/19 at 9:30 AM. The lactulose was omitted from the preparation and was not administered to Resident #3 during the medication pass on 04/04/19 at 9:30 AM. An interview was conducted with MA #1 on 04/04/19 at 9:37 AM. MA #1 stated that she did not administer the lactulose because Resident #3 was out of the medication. She stated that she checked the supply room and could not find any and Lactulose was not something that was in the facility's emergency kit. MA #1 stated that she would just circle in on the medication administration record (MAR) and then document on the back that she was out of it. She added that she would reorder from the pharmacy and "hopefully it would be delivered tonight." An interview was conducted with the Assistant Director of Nursing (ADON) on 04/04/19 at 12:34 PM. The ADON stated that the pharmacy sent boxes of medications to the residents and when there were only a few days supply of the mediation left there was sticker indicating it was	F 760	until sustained compliance met.	

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F 760	Continued From page 5 time to reorder the medication. The staff would pull that sticker and fax it to the pharmacy and they would deliver the medication on the next scheduled delivery to the facility. The ADON added that the pharmacy delivered daily to the facility usually in the late evening hours. The ADON stated that if a resident was out of a medication staff should check the back up supply in the medication room including the emergency kit supplied by the pharmacy. The ADON added that if the medication was not available then they should contact the Nurse Practitioner (NP) or medical provider and obtain additional orders. An interview was conducted with the Director of Nursing (DON) on 04/04/19 at 12:42 PM. The DON stated that each box of medication included a reorder sticker and when there were only a few days supply of the medication left the staff should pull the reorder sticker and fax it the pharmacy. She added that the pharmacy would refill the medication and deliver it to the facility on the next scheduled delivery. The DON stated that the pharmacy delivered daily to facility between the hours of 12:00 AM and 3:00 AM. The DON stated that if the nursing staff were out of a medication while on the medication pass they should check the back up supply of medication including the emergency kit in the medication room. If the medication was not located in the back up or emergency kit, then the staff should contact the NP or medical provider and obtain additional orders. She stated that it was not appropriate to just circle the medication on the MAR and not administer the medication the NP should be made aware and new orders obtained. An interview was conducted with NP on 04/04/19 at 1:43 PM. The NP stated that typically if the	F 760		

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F 760	Continued From page 6 nursing staff was out of a medication they would find out from the pharmacy why they were out of the medication and then notify the medical provider. The NP stated that she has had no calls from the facility staff today regarding any medications that were unavailable for Resident #3. She stated that Resident #3 received the lactulose for chronically elevated ammonia levels and it was very important that he received the Lactulose as ordered. She added that she would not be so concerned with just one missed dose but if Resident #3 missed multiple doses she would be gravely concerned. The NP stated that she would expect the nursing staff to contact her if the medications were unavailable to administer so that further orders could be obtained.	F 760		