STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425287	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAGNOLIA MANOR - COLUMBIA	1007 N KING ST COLUMBIA, SC 29223

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to ensure the participation of all mandated disciplines in the Care Plan Conference for 3 out of 18 residents sampled for Care Plans (Residents #64, #70 and #74). The findings include: The facility admitted Resident #74 with [DIAGNOSES REDACTED]. Record review on 03/05/2020 at approximately 11:24 AM revealed a Care Plan Conference Summary dated 02/13/2020 listing the attendees of the Care Plan Conference for Resident #74. The list of facility staff did not include an RN or representative from Dietary. In an interview on 03/05/2020 at approximately 12:43 PM the facility Administrator confirmed no Registered Nurse and no representative from Dietary were documented as participating in the Care Plan conference for Resident #74. The facility admitted Resident #64 with [DIAGNOSES REDACTED]. Record review on 03/06/2020 at approximately 9:13 AM revealed a Care Plan Conference Summary dated 02/14/2020 listing the attendees of the Care Plan Conference for Resident #64. The list of facility staff did not include a Registered Nurse (RN) or representative from Dietary. In an interview on 03/06/2020 at approximately 10:40 AM the Director of Nursing (DON) confirmed no RN and no representative from Dietary were documented as participating in Resident #64's Care Plan Conference. In an interview on 03/06/2020 at approximately 10:51 AM the facility Administrator provided a copy of the facility policy entitled Person Centered Care Plan Process and confirmed the Care Plan Conference is to be conducted by the Interdisciplinary Team which is to include a Registered Nurse and a representative from Dietary. On 3/5/2020 at approximately 4:00 PM, a review of the medical record for Resident #70 failed to show attendance at a Care Plan Meeting on 2/21/2020 by an RN, Dietician and Certified Nursing Assistant . On 3/5/2020 at approximately 4:12 PM, this finding was verified by the Social Services Director who stated that neither a RN, Dietician or Certified Nursing Assistant attended the Care Plan Meeting.
F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews the facility failed to assure proper care related to [DEVICE] (gastric tube) feeding/medication administration for Resident #18 based 1 of 1 residents observed for [DEVICE] during medication pass. Resident #18 had been admitted on [DATE] with [DIAGNOSES REDACTED]. (Cross refer F759) The findings include: On 3/05/2020 at approximately 9:20 AM, RN #1 prepared seven medications in separate medicine cups for administration by way of G-(gastric) tube to Resident #18. Three of these medications ([MEDICATION NAME] 200-300, Magnesium Oxide 400 mg x 2 and Sodium [MEDICATION NAME] 650 mg x 2) were separately crushed, but not to a fine powder; the other medications were either liquid or powder and did not require crushing. All medications and approximately 8 ounces of ice water from the water pitcher on the medication cart were taken into the resident's room and placed on a table opposite the end of the resident's bed. The [MEDICATION NAME] 1.5 nutritional supplement tube feeding, running at 55 ml (milliliters)/hr (hour), was stopped and the resident was raised from an angle of approximately 5-10 degrees to approximately 35 degrees. At that point a significant amount of a thick brown liquid flowed from the resident's mouth onto the bed sheet. The nurse checked for residual with approximately 30 ml of ice water and added approximately 15 ml of ice water to each medication, stirring with the tip of a syringe. On 3/5/2020 at approximately 9:31 AM, [MEDICATION NAME] [MEDICATION NAME] 220 mg (milligrams)/5 ml, 1.4 ml was administered with no problem and at approximately 9:35 AM, [MEDICATION NAME] 200-300 was administered, but residual medication was left clinging to the inside of the medicine cup. At approximately 9:39 AM, two tablets of Magnesium Oxide 400 mg were administered by using the syringe plunger to apply light pressure, but some of the medication spilled onto the resident's left arm. At approximately 9:45 AM, administration of two tablets of Sodium [MEDICATION NAME] 650 mg was attempted, but would not flow into the [DEVICE]. At that point, the resident started experiencing what appeared to be chest pain and the Surveyor alerted the DON (Director of Nursing) who came to the resident's room. Further attempts to administer mediations ceased, vital signs (blood pressure = 128/80, pulse = 72, pulse oximeter = 92 and temperature = 97.7 degrees Fahrenheit) were taken at approximately 9:52 AM, the Nurse Practitioner was notified and orders provided for alternative medications related to chest pain. On 3/5/2020 at approximately 11:07 AM, during medication reconciliation a review of the March, 2020 physician orders [REDACTED]. Every Shift. Enteral Feeding: Flush tube with 20 cc (cubic centimeters/milliliters) warm water before and after medication administration. On 3/05/2020 at approximately 12:17 PM, the Assistant Director of Nursing provided a copy of the Medication Management policy (revised 7/1/2016) related to administering enteral medications, Subsequent review at approximately 12:20 PM revealed: 13. A. Check position of patient/resident (40+ degrees). 13 .C. 3. If liquid form is unavailable, crush tablet to a fine powder and mix thoroughly with 10-15 ml warm water in a medicine cup and rinse the cup to get all medication. On 3/5/2020 at approximately 12:30 PM, the DON and Nurse Consultant concurred with these errors, that there were problems associated with not following physician orders [REDACTED].
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews the pharmacy failed to identify an expired medication during monthly inspections in 1 of 5 medication carts. (Cross refer F761) The findings include: On [DATE] a approximately 11:05 AM inspection of the South Wing Medication Cart # 1 revealed one opened house stock bottle of Rena-Vite by Cypress Lot 1 expired ,[DATE]. On [DATE] at approximately 6:55 PM a medical record review showed that none had been administered since last survey [DATE] and that the Pharmacy had performed a random sampling review of Midland South 1 on [DATE] and stated no outdated/discontinued meds. On [DATE] during an interview at approximately 9:52 AM this finding was confirmed by the Nurse Consultant.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews the facility failed to assure a medication error rate of less than 5 % (percent). The rate was 14.8 % based on 4 errors out of 27 observations. (Cross refer F693) The findings include: ERROR # 1: On 3/03/2020 at approximately 10:36 AM, RN (Registered Nurse) # 1 administered 25 units of Humalog Mix 75-25 to the

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

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 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) right deltoid of Resident # 33. During medication reconciliation on 3/3/2020 at approximately 11:32 AM a review of the March, 2020 physician's orders [REDACTED].} Once a Morning; 8:00 AM. Allowing +/- one hour from 8:00 AM, the administration time of 10:36 AM made the dose approximately one hour and 30 minutes late. On 3/3/2020 at approximately 12:15 PM, this finding was confirmed by RN # 1 who stated that s/he stated late giving medications. ERRORS # 2, 3 & 4: On 3/05/2020 at approximately 9:20 AM, RN # 1 prepared seven medications in separate medicine cups for administration by way of G-(gastric) tube to Resident #18. Three of these medications ([MEDICATION NAME] 200-300, Magnesium Oxide 400 mg x 2 and Sodium [MEDICATION NAME] 650 mg x 2) were separately crushed, but not to a fine powder; the other medications were either liquid or powder and did not require crushing. All medications and approximately 8 ounces of ice water from the water pitcher on the medication cart were taken into the resident's room and placed on a table opposite the end of the resident's bed. The [MEDICATION NAME] 1.5 nutritional supplement tube feeding, running at 55 ml (milliliters)/hr (hour), was stopped and the resident was raised from an angle of approximately 5-10 degrees to approximately 35 degrees. At that point a significant amount of a thick brown liquid flowed from the resident's mouth onto the bed sheet. The nurse checked for residual with approximately 30 ml of ice water and added approximately 15 ml of ice water to each medication, stirring with the tip of a syringe. On 3/5/2020 at approximately 9:31 AM, [MEDICATION NAME] [MEDICATION NAME] 220 mg (milligrams)/5 ml, 1.4 ml was administered with no problem and at approximately 9:35 AM, [MEDICATION NAME] 200-300 was administered, but residual medication was left clinging to the inside of the medicine cup. At approximately 9:39 AM, two tablets of Magnesium Oxide 400 mg were administered by using the syringe plunger to apply light pressure, but some of the medication spilled onto the resident's left arm. At approximately 9:45 AM, administration of two tablets of Sodium [MEDICATION NAME] 650 mg was attempted, but would not flow into the [DEVICE]. At that point, the resident started experiencing what appeared to be chest pain and the Surveyor alerted the DON (Director of Nursing) who came to the resident's room. Further attempts to administer mediations ceased, vital signs (blood pressure = 128/80, pulse = 72, pulse oximeter = 92 and temperature = 97.7 degrees Fahrenheit) were taken at approximately 9:52 AM, the Nurse Practitioner was notified and orders provided for alternative medications related to chest pain. On 3/5/2020 at approximately 11:07 AM, during medication reconciliation a review of the March, 2020 physician orders [REDACTED]. Every Shift. Enteral Feeding: Flush tube with 20 cc (cubic centimeters/milliliters) warm water before and after medication administration. On 3/05/2020 at approximately 12:17 PM, the Assistant Director of Nursing provided a copy of the Medication Management policy (revised 7/1/2016) related to administering enteral medications, Subsequent review at approximately 12:20 PM revealed: 13. A. Check position of patient/resident (40+ degrees). 13 .C. 3. If liquid form is unavailable, crush tablet to a fine powder and mix thoroughly with 10-15 ml warm water in a medicine cup and rinse the cup to get all medication. On 3/5/2020 at approximately 12:30 PM, the DON and Nurse Consultant concurred with these errors, that there were problems associated with not following physician orders [REDACTED].
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, interviews, manufacturer and pharmacy labeling and manufacturer package inserts the facility failed to assure that time-sensitive medications were not dated when opened in 2 of 2 medication rooms, that a sterile, one-time use only medication was stored for re-use, and the bottom drawer was not clean in 1 of 2 treatment carts, that time-sensitive medications were not labeled when opened, medications were not stored at the correct temperature, and that expired medications were not removed from active storage in 3 of 5 medication carts. (Cross refer F755) The findings: On 3/03/2020 at approximately 9:58 AM inspection of the South Medication Room refrigerator revealed the following: -One opened and undated vial of [MEDICATION NAME] PPD (Purified Protein Derivative), [MEDICATION NAME] 5 TU (test unit)/0.1 ml (milliliter), 1 ml (10 tests) by PAR Pharmaceuticals approximately 1/2 full Lot 3 with no date of dispensing on the label. -One opened and undated vial of [MEDICATION NAME], PPD, [MEDICATION NAME] 5 TU/0.1 ml ,1 ml (10 tests) by PAR Pharmaceuticals approximately 1/2 full Lot 1 with no date of dispensing on the label. On 3/03/2020 9:44 AM LPN (Licensed Practical Nurse) #1 verified that both vials had been opened and had not been dated when opened. On 3/03/2020 at approximately 10:31 AM inspection of the North Medication Room refrigerator revealed the following: -One opened and undated vial of [MEDICATION NAME] PPD, [MEDICATION NAME] 5 TU (test unit)/0.1 ml (milliliter) 1 ml (10 tests) by PAR Pharmaceuticals approximately 1/2 full Lot 3 with no date of dispensing on the label. -One opened and undated vial of [MEDICATION NAME], PPD, [MEDICATION NAME] 5 TU/0.1 ml 1 ml (10 tests) by PAR Pharmaceuticals approximately 1/10 full Lot 1 with no date of dispensing on the label. On 3/03/2020 9:44 AM LPN #2 verified that both vials had been opened and had not been dated when opened. Each of these four vials had been labeled by PAR Pharmaceuticals: Once entered vial should be discarded after 30 days. The PAR Pharmaceuticals package insert for [MEDICATION NAME] PPD, [MEDICATION NAME] states: Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency. On 3/03/2020 at approximately 10:47 AM inspection of the South Wing Treatment Cart revealed one opened and partially used tube of Thera Honey Gel 1.5 ounce labeled as sterile and single use by the manufacturer and one opened 32 ounce bottle of [MEDICATION NAME] with a pink substance spilled on the sides of bottle and in the bottom of the treatment cart. On 3/03/2020 at approximately 11:12 AM these findings were verified by LPN #1 who stated that the Thera Honey Gel was opened, being used on different residents and that s/he had intended to clean the spill from the treatment cart and bottle. On 3/03/2020 at approximately 11:05 AM inspection of the South Wing Medication Cart #1 revealed the following: -One vial of [MEDICATION NAME] Insulin 100 U (units)/ml FSBS (finger stick blood sugar) BID (two times daily) belonging to Resident #3 was dated as opened 1/3/2020 and had been labeled by pharmacy Discard unused medication after 28 days. -One opened and half full bottle of Acidophilus [MEDICATION NAME] 1 B (billion) CFU (colony forming units)/serving by Health Star, labeled as floor stock was stored in top drawer of the medication cart. The opened bottle had been labeled by the manufacturer Refrigerate after Opening. -One opened house stock bottle of Rena-Vite by Cypress Lot 1 expired 12/18. On 3/03/2020 at approximately 6:55 PM a medical record review showed that none had been administered since last survey 11/22/2019. -One opened Humalog Kwikpen belonging to Resident #20 was not dated and had been labeled by pharmacy Discard unused medication after 28 days. -One opened [MEDICATION NAME] belonging to Resident # 20 was not dated and had been labeled by pharmacy Discard unused medication after 28 days. -One opened [MEDICATION NAME] belonging to Resident #3 (based on a handwritten name) was not dated and had been labeled by pharmacy Discard unused medication after 28 days. -One opened [MEDICATION NAME] with no resident name was not dated and had been labeled by pharmacy Discard unused medication after 28 days. On 03/03/2020 at approximately 11:15 AM LPN #3 verified that these insulin containers had been opened, were in use and had not been dated when opened. On 03/03/2020 at approximately 11:25 AM inspection of the North Wing Medication Cart # 3 revealed the following: -One opened [MEDICATION NAME] belonging to Resident #67 was not dated when opened and had been labeled by pharmacy Discard unused medication after 28 days. -Two opened [MEDICATION NAME] FlexTouch belonging to Resident #69 had not dated when opened and had been labeled by pharmacy Discard unused medication after 42 days. -One opened and expired 30 ml vial of [MEDICATION NAME] Solution USP (United States Pharmacopoeia) 20% (percent) 200 mg/ml Preservative Free by Fresenius, approximately 1/8 full belonging to Resident #86 and labeled by the facility as opened 2/27. The manufacturer's label states: Store in refrigerator (2-8 degrees C (Centigrade) 36-46 degrees F (Fahrenheit) after opening. Discard opened container after 96 hours. On 03/03/2020 at approximately 11:38 AM these expired medication and improperly stored medication findings were verified by LPN #4 who stated that s/he had given a dose of [MEDICATION NAME] earlier in the day and that [MEDICATION NAME] was also administered by a Respiratory Therapist when on duty. On 3/3/2020 at approximately 11:49 AM inspection of the North Wing Medication Cart 2 revealed the following: -One opened [MEDICATION NAME] dated as opened 2/1/2020 and labeled by the pharmacy Discard unused medication after 28 days. -One opened and 3/4 full bottle of Acidophilus [MEDICATION NAME] 1 B CFU/serving by Health Star, labeled as floor stock was stored in top drawer of the medication cart. The opened bottle had been labeled by the manufacturer Refrigerate after Opening. On 3/03/2020 at approximately 11:53 AM these findings were verified by LPN #5 who acknowledged that the [MEDICATION NAME] was past the 28 day expiration period On 3/3/2020 a review of the MANUFACTURER PACKAGE INSERT INSTRUCTIONS FOR USE AFTER OPENING revealed the following guidelines: [MEDICATION NAME] Insulin vial manufacturer's (Novo-[MEDICATION NAME]) package insert states once opened, product must be used within 28 days. [MEDICATION NAME] manufacturer's (Novo-[MEDICATION NAME]) package insert

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F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) states once opened, product must be used within 28 days. Humalog Kwikpen manufacturer's (Eli Lilly & Co.) package insert states once opened, product must be used within 28 days. [MEDICATION NAME] manufacturer's (Sanofi-Aventis) package insert states once opened, product must be used within 28 days. [MEDICATION NAME] FlexTouch manufacturer's (Novo-[MEDICATION NAME]) package insert states once opened, product must be used within 42 days.