	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G		ATE SURVEY	
			A. BOILDIN	<u> </u>	С		
		345219	B. WING		07/21/2016		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
MAGNOLI	A LANE NURSING AN	D REHABILITATION CENTER		107 MAGNOLIA DRIVE MORGANTON, NC 28655			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG		TION SHOULD BE COMPLET THE APPROPRIATE DATE		
F 253 SS=D	483.15(h)(2) HOUS MAINTENANCE SE		F 2	53		8/18/16	
	The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.						
	by: Based on observat facility failed to labe	NT is not met as evidenced tions and staff interview the al and properly store personal		On 7/21/16, the toothbrush toothpaste found on the sh	elf on the shelf		
	2 of 2 resident halls The findings include			of resident #94 over a shar removed and discarded. A toothbrush and toothpaste the shelf over the shared s	new were placed on ink labeled and		
	10:25 AM revealed uncovered toothbru	of room 94 A on 07/18/16 at three unlabeled and ishes and an unlabeled tube of elf over a shared sink.		covered as indicated by the Facilitator (SF). The tooth shaving cream and mouth to resident #98 found on th shared sink were removed	brush, a can of wash belonging ne shelf of a		
	Observations of roc	om 94 A on 07/19/16 at 9:31 ree unlabeled and uncovered		A new toothbrush, can of s and mouthwash were place labeled and covered as inc	having cream ed on the shelf		
		n unlabeled tube of toothpaste		SF. The unlabeled toothbr and 2 washbasins belongir #104 found on a shelf and/	rush, bedpan ng to resident		
	revealed three unla	om 94 on 07/20/16 at 9:18 AM beled and uncovered n unlabeled tube of toothpaste		bathroom were removed a A new toothbrush, bedpan were provided, labeled and	nd discarded. and washbasin		
	on a shelf over a sh			indicated by the SF. The to tubes of toothpaste, 2 tooth and a bedpan belonging to	oothbrush, 2 nbrush holders		
	revealed three unla	beled and uncovered n unlabeled tube of toothpaste		toothbrush, toothpaste, too and bedpan were provided	ed. A new hbrush holder		
	During an interview	on 07/21/16 at 3:02 PM the		covered as indicated by the washbasin belonging to res	e SF. The sident #110 was		
D	-	(DON) stated she expected roducts to be labeled with the		removed and discarded. A washbasin was provided, la			

08/12/2016

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.

**Electronically Signed** 

OLIVILI	S FUR WEDICARE &	MEDICAID SERVICES				<u>OMB NC</u>	0.0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		LETED	
		345219	B. WING			C 07/21/2016		
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	011	21/2010	
MAGNOL	A LANE NURSING AND	REHABILITATION CENTER			07 MAGNOLIA DRIVE			
		-		M	ORGANTON, NC 28655			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE	
F 253	Continued From page	e 1	F 25	53				
		ed in a bag, and stored in			covered, by the SF.			
	bedpans and wash ba	asins should be labeled with			Using an audit tool, a 100% audit was			
		wrapped in a clear trash			completed by the Administrator and Sta			
	bag, and stored off th	ie floor.			Facilitator (SF) by 8/12/16, to ensure the			
	b Observations of ro	oom 98 on 07/18/16 at 11:01			all personal hygiene items (toothbrush, toothpaste, toothbrush holders, shaving			
		abeled and uncovered			cream, mouthwash, soap, bedpans,	9		
	toothbrush, one unlat	beled can of shaving cream,			washbasins, urinals) were labeled and/	′or		
		ottle of mouthwash on a shelf			covered if stored in the bathroom or sir			
	over a shared sink.				area shared by other residents and tha			
	Observations of room	1 98 on 07/19/16 at 10:25			no items were being stored on the floor Any items found unlabeled, uncovered			
		abeled and uncovered			on the floor in areas shared by other	01		
		beled can of shaving cream,			residents were removed and discarded	l		
		ottle of mouthwash on a shelf			with replacement items provided to			
	over a shared sink.				include appropriate labeling and covere as indicated.	ed		
		1 98 on 07/20/16 at 12:35						
		unlabeled and uncovered			100% of nursing staff, Administrator,	or.		
		beled can of shaving cream, bttle of mouthwash on a shelf			DON, MDS Coordinator, Staff Facilitate Accounts Payable Manager, Accounts	л,		
	over a shared sink.				Receivable Manager, Maintenance			
					Director, Housekeeping/Laundry			
		n 98 on 07/21/16 at 10:35			Supervisor, Dietary Manager, Social			
		abeled and uncovered			Worker, Activity Director, and Medical			
		beled can of shaving cream,			Records Manager were in-serviced by			
	over a shared sink.	ottle of mouthwash on a shelf			Staff Facilitator on 8/11/16 regarding the need to label and cover personal hygie			
					and/or toileting items, to ensure no			
	During an interview o	n 07/21/16 at 3:02 PM the			personal items are being stored on the			
		OON) stated she expected			floor and to check the shared			
		ducts to be labeled with the			bathrooms/sink shelves of assigned			
	the bedside table. Th	ed in a bag, and stored in			rooms for unlabeled or uncovered personal hygiene items with instruction	on		
		asins should be labeled with			the procedure to follow if any identified			
	-	wrapped in a clear trash			Newly hired licensed nursing staff will			
	bag, and stored off th				receive the in-service by the SF during			
					orientation regarding the need to label	and		

Event ID: 63TY11

Facility ID: 923027

If continuation sheet Page 2 of 29

	OF DEFICIENCIES - CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	NO. 0938-039 ATE SURVEY OMPLETED	
	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING	3		C	
		345219	B. WING			07/21/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	θE		
MAGNOL	IA LANE NURSING AND	REHABILITATION CENTER		107 MAGNOLIA DRIVE MORGANTON, NC 28655			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE	
F 253	<ul> <li>253 Continued From page 2</li> <li>c. Observations of the shared bathroom for room 104 on 07/18/16 at 11:12 AM revealed one unlabeled and uncovered toothbrush on the back of the sink. In addition, there was one unlabeled and uncovered grey bedpan, and two unlabeled and uncovered grey wash basins on the floor near the toilet.</li> <li>Observations of the shared bathroom for room 104 on 07/19/16 at 9:26 AM revealed one unlabeled and uncovered toothbrush on the back of the sink. In addition, there was one unlabeled and uncovered grey bedpan, and two unlabeled and uncovered grey bedpan with the resident at 8:42 AM revealed one unlabeled and uncovered toothbrush on the back of the sink and one unlabeled pink bedpan wrapped in a clear bag on the floor near the toilet.</li> <li>During an interview on 07/21/16 at 3:02 PM the Director of Nursing (DON) stated she expected personal hygiene products to be labeled with the resident's name, placed in a bag, and stored in the bedside table. The DON further stated bedpans and wash basins should be labeled with the residents' name, wrapped in a clear trash bag, and stored off the floor.</li> </ul>		F 25	<ul> <li>cover personal hygiene and/c items, to ensure no personal being stored on the floor and shared bathrooms and sink s assigned rooms for unlabeled uncovered personal hygiene instruction on the procedure f any identified.</li> <li>Using an audit tool, the Admi Social Worker, Accounts Pay Manager, Accounts Receivat Maintenance Director, Housekeeping/Laundry Supe Coordinator, Staff Facilitator, Records Manager, Activity Di Receptionist will make one ro scheduled work day of 2-4 as rooms to ensure no unlabeled uncovered items are being st residents shared bathroom, s or on the floor. These rounds continue indefinitely with the given to the Administrator for</li> </ul>	items are to check the helves of d or items with to follow if nistrator, able ole Manager, rvisor, MDS Medical rector and ound on each osigned d and/or ored in the sink shelves s will audit tools		
				weekly. The audit tools will be review by the Executive QI Committe identification of potential trend development of plans of action determine the need for contine monitoring.	ed monthly ee for ds and on to		

Facility ID: 923027

If continuation sheet Page 3 of 29

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345219	B. WING				C 21/2016
NAME OF P	ROVIDER OR SUPPLIER	I		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MAGNOL	A LANE NURSING AND	REHABILITATION CENTER			107 MAGNOLIA DRIVE MORGANTON, NC 28655		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 253	<ul> <li>d. Observations of rop PM revealed one unlat toothbrush on the sheet the shared bathroom and uncovered bedpat toilet.</li> <li>Observations of room PM revealed one unlat toothbrush and two un on the shelf over the stal also two unlabeled to back of the sink. In the was one unlabeled ar floor next to the toilet.</li> <li>Observations of room AM revealed one unlat toothbrush and two un on the shelf over the stal also two unlabeled ar floor next to the toilet.</li> <li>Observations of room AM revealed one unlat toothbrush and two un on the shelf over the stal also two unlabeled to back of the sink. In the was one unlabeled ar floor next to the toilet.</li> <li>During an interview on Director of Nursing (E personal hygiene pro- resident's name, plac the bedside table. The bedpans and wash bas the residents' name, we bag, and stored off the 110 on 07/19/16 at 9: uncovered wash basis The wash basin had to</li> </ul>	bom 88 on 07/18/16 at 3:01 abeled and uncovered elf over the shared sink. In there was one unlabeled an on the floor next to the a 88 on 07/20/16 at 12:23 abeled and uncovered nlabeled tubes of toothpaste shared sink. There were othbrush holders on the ne shared bathroom there nd uncovered bedpan on the a 88 on 07/21/16 at 10:37 abeled and uncovered nlabeled tubes of toothpaste shared sink. There were othbrush holders on the ne shared bathroom there nd uncovered bedpan on the a shared sink. There were othbrush holders on the ne shared bathroom there nd uncovered bedpan on the as shared bathroom there and uncovered bedpan on the a shared bathroom there and uncovered bedpan on the a shared bathroom there and uncovered bedpan on the as shared sink should be labeled with the ed in a bag, and stored in ne DON further stated as as should be labeled with wrapped in a clear trash e floor.	F	253			

Facility ID: 923027

If continuation sheet Page 4 of 29

	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 08/22/2016 RM APPROVED IO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION		E SURVEY IPLETED
		345219	B. WING		0.	7/21/2016
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
MAGNOL	A LANE NURSING AND	REHABILITATION CENTER	107	MAGNOLIA DRIVE		
			мо	RGANTON, NC 28655		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 253	Continued From page marker.	9 4	F 253			
F 272 SS=E	110 on 07/20/16 at 12 uncovered wash basi The wash basin had to on the side and one we marker. In addition, to uncovered toothbrush Observations of the s 110 on 07/21/16 at 8: uncovered wash basi The wash basin had to on the side and one we marker. In addition, to uncovered toothbrush During an interview of Director of Nursing (E personal hygiene pro- resident's name, place the bedside table. The bedpans and wash basis the residents' name, we bag, and stored off the 483.20(b)(1) COMPR ASSESSMENTS The facility must come a comprehensive, accor reproducible assession functional capacity. A facility must make a assessment of a resident assessment	n on the floor near the toilet. two different names written was crossed off with a black here was one unlabeled and n on the back of the sink. n 07/21/16 at 3:02 PM the DON) stated she expected ducts to be labeled with the red in a bag, and stored in he DON further stated asins should be labeled with wrapped in a clear trash e floor. EHENSIVE	F 272			8/18/16

Facility ID: 923027

If continuation sheet Page 5 of 29

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08 FORM API OMB NO. 09	PROVED	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345219	B. WING		07/21/2	016	
		REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 107 MAGNOLIA DRIVE			
MACIOL				MORGANTON, NC 28655			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) MPLETION DATE	
F 272	Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior p Psychosocial well-be Physical functioning a Continence; Disease diagnosis ar Dental and nutritiona Skin conditions; Activity pursuit; Medications; Special treatments an Discharge potential; Documentation of sur the additional assess areas triggered by the Data Set (MDS); and	nographic information; atterns; ing; and structural problems; ind health conditions; I status; ind procedures; mmary information regarding ment performed on the care e completion of the Minimum	F 272				
	This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to complete Care Area Assessments that addressed the underlying causes, contributing factors and risk factors for 5 of 19 sampled residents (Residents #50, #23, #1, #44, #39).			On 8/12/16, the MDS Coordinator completed a general care plan progr note of resident #50 and #23 related the Psychotropic Drug Use Care Are Assessment (CAA). The notes inclu description of the problem, name/doo the medications, underlying causes, contributing factors and risk factors	to a de a		

Event ID: 63TY11

Facility ID: 923027

If continuation sheet Page 6 of 29

	-	ND HUMAN SERVICES MEDICAID SERVICES					RINTED: 08/22/20 FORM APPROVE /IB NO: 0938-03	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		STRUCTION	(X:	3) DATE SURVEY COMPLETED	
		345219	B. WING			C 07/21/2016		
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET	TADDRESS, CITY, STATE, ZIP COD	E		
MAGNOLI	A LANE NURSING AND	REHABILITATION CENTER			AGNOLIA DRIVE GANTON, NC 28655			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 272	Continued From page	e 6	F 27	2				
	The findings included	l: admitted to the facility on ses including seizure		rela me pro dea Co pla rela	ated to the use of psychotro edications supporting the ne baceed to care plan. Reside ceased. On 8/12/16, the MI bordinator completed a gene an progress note for resider ated to his chronic diagnos	eed to ent #1 has DS eral care nt #44 is of		
	dated 01/27/16 revea	Minimum Data Set (MDS) aled Resident #50 was mpaired with long and short nent.		Parkinson's Disease Care Area Assessment (CAA) to include analysis of findings with details regarding his condition and how these impact his treatment plan determining the need to proceed to care plan. On 8/12/16, the MDS Coordinator completed a general				
	summary for Psychol 02/13/16 revealed Re antidepressant and a CAA stated use of ps (antidepressant, antia side effects of cardia	anxiety) with the potential for c, neuromuscular,		cai rela As cai info det	re plan progress note for re ated to his Nutritional Statu sessment (CAA). The note uses, risk factors and how t ormation impacted his nutri termining need to proceed	esident #39 Is Care Area e identifies this itional status to care plan		
	no injury related to m through the next revie per physician's order side effects of medica reduction/elimination Mini-mental evaluatio Worker), monitor resi functioning on ongoir signs per facility prote not paint a picture of strengths and weakn	w no side effects of rough next review. Will have redication usage/side effects ew. Administer medications s, evaluate effectiveness and ations for possible of psychotropic drugs. on per facility protocol (Social		And Ca Ps and the col res Are add col rela	sing an audit tool, the Staff I d DON will review 100% of are Area Assessments (CAA cychotropic Drug Use, Nutrit d Diagnosis by 8/18/16 to e e CAA's address the underly ntributing factors and risk fa sidents per the RAI Manual ea Assessments (CAA) idea dressing the underlying cau ntributing factors and risk fa ated to Psychotropic Drug I utritional Status and Diagno rrected per the RAI Manual	resident A) related to tional Status ensure that ying causes actors for ou . Any Care ntified as no uses, actors Use, sis will be	, r	
	factors.			in-	e MDS nurse and DON we serviced on 8/6/16 by the S cilitator regarding the CAA	Staff	1	

Facility ID: 923027

If continuation sheet Page 7 of 29

		MEDICAID SERVICES				OMB NC	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION		LETED
		345219	B. WING				C 21/2016
	ROVIDER OR SUPPLIER	I	T	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0//	21/2010
		REHABILITATION CENTER		10	07 MAGNOLIA DRIVE		
ACIOL				М	IORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 272	Continued From page	e 7	F 2	72			
		n 07/21/16 at 2:43 PM the			CAA documentation requirements per	the	
		he had been taught to write			RAI Manual to include the need to		
		checking all of the boxes			determine underlying causes, contribu	ting	
		ions in each box by the			factors and risk factors of each probler		
	-	e. She stated she had never			identified during the MDS assessment		
		a summary describing the					
		and weaknesses and what			Using an audit tool, the DON will review 50% of Psychotropic Drug Use, Nutrition		
	factors contributed to planned.	the area being care			and Diagnosis Care Area Assessments		
	plaimeu.				written weekly x 8 weeks then 25% of	5	
					Care Area Assessments written weekly	v x	
	During an interview c	onducted on 07/21/16 at			8 weeks to ensure each CAA has	,	
	2:55 PM the Director	of Nursing stated she had			addressed the underlying causes,		
		od what was required in the			contributing factors and risk factors. A	ny	
	CAA Summary and s	-			identified CAA not meeting the		
	Corporate MDS Nurs do the summaries co	e to teach MDS staff how to			documentation guidelines per the RAI manual will be corrected prior to the		
	do the summanes co	necuy.			required completion date.		
	2. Resident #23 was	admitted to the facility on			The audit tools will be reviewed by the		
	-	ses of chronic obstructive			Executive QI Committee monthly for		
	pulmonary disease, r	espiratory failure and			identification of potential trends and		
	depression.				development of plans of action to determine the need for continued		
					monitoring.		
		Minimum Data Set (MDS) Iled Resident #23 was			nontonig.		
		rea Assessment (CAA)					
		tropic Drug Use dated					
	antidepressant, antia	•					
		A stated use of psychotropic					
		it, antianxiety) with the					
	potential for side effe	cts of cardiac,					
		ointestinal systems to					
	diagnoses of depress	sion. Will show no side					

If continuation sheet Page 8 of 29

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/22/2016 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345219	B. WING		C 07/21/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	
MAGNOL	A LANE NURSING AND	REHABILITATION CENTER		107 MAGNOLIA DRIVE MORGANTON, NC 28655	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE COMPLETION D THE APPROPRIATE DATE
F 272	effects of medications Will have no injury re usage/side effects the Administer medicatio evaluate effectiveness medications for possi psychotropic drugs. M mood/behaviors (anx restlessness, decreas documentation per fa of any significant cha facility protocol. Phar monthly and/or as ord did not paint a picture strengths and weakn underlying causes, co factors. During an interview on Nurse #2 stated she CAA Summary by che placing interventions Corporate MDS Nurs been trained to write resident's strengths a factors contributed to planned. During an interview of 2:55 PM the Director never really understo CAA Summary and s Corporate MDS Nurs do the summaries co	s taken through next review. lated to medication rough the next review. ns per physician 's orders, is and side effects of ible reduction/elimination of Monitor resident's iety, tearfulness, sed appetite, insomnia) with icility policy. Notify physician nges. Monitor vital signs per macy review of medications dered. The CAA summary e of the resident or include esses of the resident, ontributing factors and risk in 07/21/16 at 2:43 PM had been taught to write the ecking all of the boxes and in each box by the e. She stated she had never a summary describing the and weaknesses and what the area being care	F 2	.72	

	-	ND HUMAN SERVICES MEDICAID SERVICES					INTED: 08/22/2016 FORM APPROVED IB NO. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		DNSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345219	B. WING				07/21/2016	
NAME OF PI	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP COD	)E		
MAGNOLI	A LANE NURSING AND	REHABILITATION CENTER			MAGNOLIA DRIVE			
		-		MO	RGANTON, NC 28655			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 272	Continued From page	<b>_</b> Q	F 2	72				
	03/23/94 with diagno	ses of traumatic brain injury, anxiety and depression.						
		Minimum Data Set dated esident #1 was severely						
	summary dated 11/07 required an antidepre medication. The CAA an altering effect on t for side effects of car gastrointestinal syste bipolar disorder, decl depression, psychosi medications through therapeutic dose through therapeutic dose through therapeutic dose through therapeutic set physicia to physician. Monitor functioning on ongoir mood/behaviors (yell self or thins) with door protocol. The CAA su picture of the residen	ms due to diagnoses of ine in mood/behavior, s. Will show minimal use of next review. Will receive ough next review. Administer sicians order. DISCUS protocol. Monitor drug blood an orders and report results resident's mental status ng basis. Monitor resident's ing, aggression, throwing cumentation per facility immary did not paint a t or include strengths and esident, underlying causes,						
	Nurse #2 stated she CAA Summary by ch placing interventions Corporate MDS Nurs	on 07/21/16 at 2:43 PM had been taught to write the ecking all of the boxes and in each box by the e. She stated she had never a summary describing the						

Facility ID: 923027

If continuation sheet Page 10 of 29

		ID HUMAN SERVICES MEDICAID SERVICES					FORM A	08/22/2016 PPROVED )938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTR			X3) DATE SU COMPLET	RVEY
		345219	B. WING _				C 07/21/	/2016
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD	)E		
MAGNOLI	A LANE NURSING AND	REHABILITATION CENTER			NOLIA DRIVE NTON, NC 28655			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI) TAG		PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIAT		(X5) COMPLETION DATE
F 272	A LANE NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 resident's strengths and weaknesses and what factors contributed to the area being care planned. During an interview conducted on 07/21/16 at 2:55 PM the Director of Nursing stated she had never really understood what was required in the CAA Summary and she depended on the Corporate MDS Nurse to teach MDS staff how to do the summaries correctly. 4. Resident # 44 was admitted to the facility on 06/13/2016. A review of a Minimum Data Set (MDS) completed on 06/20/16 revealed the resident was cognitively intact, ambulatory, and was able to assist in his own care. The MDS in the area of Active Diagnosis had marked as "No" for the diagnosis of anxiety, depression, gastroesophageal reflux disease, hypertension, and Parkinson's disease. During interview on 07/18/16 at 10:00 AM the resident stated he had diagnosis of Parkinson's Disease, COPD, and had previous cerebral infarct and heart surgery. The Resident was able to communicate needs and recall facts about his care. On 07/18/16 at 4:00 PM an interview was conducted with Nurse #1 and the MDS Nurse. In the interview both nurses stated that the diagnosis listed on the MDS did not include all the diagnosis listed on the MDS did not include all the diagnosis for which the resident received treatment. The MDS Nurse confirmed that the Care Area Assessment (CAA) summary should		F 2	72				
	the interview both nu diagnosis listed on th diagnosis for which th treatment. The MDS Care Area Assessme have included an ana details regarding Res and how these impact	rses stated that the e MDS did not include all the ne resident received Nurse confirmed that the						

Facility ID: 923027

If continuation sheet Page 11 of 29

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345219	B. WING				C 21/2016
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
MAGNOL	A LANE NURSING AND	REHABILITATION CENTER			07 MAGNOLIA DRIVE ORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 272	diagnoses including e diabetes mellitus. Review of the annual dated 08/27/15 revea cognitively intact and with eating. The annu- weighed 165 pounds loss noted. The annu- received dialysis. Review of the Care A summary for Nutrition revealed Resident #3 body weight range an pounds. The CAA sta unavailable at the tim summary did not inclu- had triggered and did factors and how this i nutritional status. An interview with the PM revealed she had CAA Summary by che placing interventions Corporate MDS Nurse been trained to write a factors contributed to planned. During an interview ci 2:55 PM the Director never really understor CAA Summary and sl	And stage renal disease and Minimum Data Set (MDS) led Resident #39 was required set up help only ual MDS noted Resident #39 and there was no weight al MDS stated Resident #39 rea Assessment (CAA) al Status dated 09/15/15 9 was just over his ideal do currently weighed 165 ated Resident #39 was e of the interview. The CAA ude why Nutritional Status not identify causes and risk nformation impacted his MDS Nurse 07/21/16 at 2:43 been taught to write the ecking all of the boxes and in each box by the e. She stated she had never a summary describing the nd weaknesses and what the area being care	F 2	272			

Facility ID: 923027

If continuation sheet Page 12 of 29

		MEDICAID SERVICES			OMB N	RM APPROVE IO. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURV COMPLETE		
		345219	B. WING		C 07/21/2016		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	E		
MAGNOLI	A LANE NURSING AND	REHABILITATION CENTER		107 MAGNOLIA DRIVE			
				MORGANTON, NC 28655			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 272	Continued From page	e 12	F 272				
		erview on 07/21/16 at 4:09					
	PM the MDS Nurse re	eviewed Resident #39's CAA					
	-	al Status dated 09/15/15					
		n completed by a dietary longer employed by the					
		rse confirmed the CAA					
	-	e had an analysis of findings					
		egarding Resident #39's					
		ysis, and therapeutic diet ted his nutritional status.					
F 278	483.20(g) - (j) ASSES		F 278			8/18/16	
SS=D		DINATION/CERTIFIED					
	The assessment mus resident's status.	t accurately reflect the					
	A registered nurse m	ust conduct or coordinate					
	each assessment wit						
	participation of health	professionals.					
	A registered nurse massessment is complete	ust sign and certify that the eted.					
	Each individual who	completes a portion of the					
		n and certify the accuracy of					
	Under Medicare and	Medicaid, an individual who					
	willfully and knowingly	y certifies a material and					
		esident assessment is					
	-	ey penalty of not more than ssment; or an individual who					
		y causes another individual					
	to certify a material a	nd false statement in a					
		is subject to a civil money					
	penalty of not more thassessment.	ian \$5,000 for each					

Facility ID: 923027

If continuation sheet Page 13 of 29

		MEDICAID SERVICES				NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · · ·	ATE SURVEY MPLETED
			A. DOILDING			С
		345219	B. WING			07/21/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				107 MAGNOLIA DRIVE		
MAGNOLI	A LANE NURSING AND	REHABILITATION CENTER		MORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 070		10				
F 278	10		F 27	8		
		t does not constitute a				
	material and false sta	atement.				
	This REQUIREMEN	T is not met as evidenced				
	by:					
		riews and staff interview the		On 8/8/16, the MDS assessm	ent for	
	facility failed to accur	ately code the Minimum		resident #1 with ARD of 10/21		
	Data Set to reflect tra			modified to include the diagno		
		and Parkinson's disease for 2		Traumatic Brain Injury (TBI) by	y the MDS	
	of 19 sampled reside	ents (Resident #1 and #44).		nurse. On 8/8/16, the MDS as	ssessment	
				for resident #44 with ARD of 6	/20/16 was	
	The findings included	d:		modified to include the diagno		
	1 Booidopt #1 woo o	dmitted to the facility on		Depression, Anxiety and Park Disease.	inson s	
		admitted to the facility on ses of traumatic brain injury,		Disease.		
		and respiratory failure.		On 8/6/16, the MDS nurse and		
				in-serviced by the Staff Facilita		
		l Minimum Data Set (MDS)		to correctly code Section I (Ac		
	dated 10/21/15 revea			Diagnosis) of the MDS per the	RAI	
		mpaired and required		Manual.		
		sistance with all activities of				
	daily living. The MDS			Using an audit tool, the Staff F		
		agnoses of traumatic brain		completed an audit of 100% re		
	injury.			last completed MDS, Section		
				Diagnosis), comparing the Me		
		nducted with the MDS Nurse		Record diagnosis as ordered l		
		PM. The MDS Nurse stated		the diagnosis coded on the MI		
	•	lent #1's annual MDS dated		I. Any MDS, Section I (Active		
	10/21/15, and his ma	-		found to be coded incorrectly		
		y. She reviewed the annual he surveyor and agreed		modified and transmitted to the Repository by 8/18/16.	e National	
		was not checked for				
	Resident #1. The ME			The DON will utilize an audit to	ool to review	
		lent were pulled over from a		50% completed MDS assessn		
	-	mission staff entered into the		weekly x 8 weeks then 25% of		
		d not check to make sure all		MDS assessments weekly x 8		
	diagnoses were code			ensure accuracy of Section I (		
				Diagnosis) prior to being trans		

Facility ID: 923027

If continuation sheet Page 14 of 29

ATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· ,		· · /	LETED	
					С		
		345219	B. WING		07/21/2016		
IAME OF PI	ROVIDER OR SUPPLIER	-	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
IAGNOLI	A LANE NURSING AND	REHABILITATION CENTER		07 MAGNOLIA DRIVE IORGANTON, NC 28655			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	
F 278	Continued From page	e 14	F 278				
	An interview conduct with the Director of N	ed on 07/21/16 at 2:55 PM ursing revealed it was her DS nurse to check the		the National Repository, with re provided as indicated.	training		
	make sure they were 2. Resident # 44 was 06/13/16. A review o (MDS) dated 06/20/1 cognitively intact, am in his own care. The the resident had rece 7 days for anxiety and Diagnosis and Active areas of anxiety and	s admitted to the facility on f the Minimum Data Set 6 revealed the resident was bulatory, and able to assist MDS assessment indicated ived treatment within the last d depression. The disease section had the depression marked as "No." n of the MDS had "No" nson's Disease. 7/18/16 at 10:00 AM		The Executive QI Committee will review the audit tools monthly for identification potential trends and development of pla of action to determine the need for continued monitoring.			
	Parkinson's disease, history of cerebral inf On 7/18/16 at 4:00 P	COPD, and a previous arct and heart surgery. M an interview was					
	Nurse # 1 verified that depression, anxiety, a all been marked as "I Nurse stated that she about the diagnosis f	<ul> <li># 1 and the MDS Nurse.</li> <li>and Parkinson's disease had</li> <li>No" on the MDS. The MDS</li> <li>had gotten the information</li> <li>rom the Long-Term Services</li> <li>FL-2) which was on the</li> </ul>					
	resident's chart. The not ask the resident of physician to verify co incomplete diagnosis monitoring and treatm	MDS Nurse stated she did or follow up with the rrect diagnosis and the list had impacted the nent plans for the resident.					
F 281 SS=D	483.20(k)(3)(i) SERV PROFESSIONAL ST	ICES PROVIDED MEET	F 281			8/18/16	

		ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 08/22/2016 ORM APPROVED NO. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345219	B. WING _				C 07/21/2016	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
MAGNOLI	A LANE NURSING AND	REHABILITATION CENTER		10	07 MAGNOLIA DRIVE			
				Μ	IORGANTON, NC 28655			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 281	Continued From page	e 15	F2	281				
	The services provide	d or arranged by the facility nal standards of quality.						
	This REQUIREMENT is not met as evidenced by: Based on record reviews and staff and Nurse				Resident #19 had an order for Lasix			
	Practitioner interview transcribe an order to Record which resulte	s, the facility failed to a Medication Administration d in a resident not being ic for edema as ordered by r for 1 of 5 residents			60mg every morning correctly transcr to the MAR on 7/21/16 by the Directo Nursing. Using an audit tool, the Staff Facilitate (SF) and Director of Nursing (DON)	r of		
	(Resident # 19).				audited 100% of our active residents verify that all physician telephone ord written in the past three(3) months (May/June/July) were transcribed			
	diagnoses including o (CHF), diabetes melli	mitted on 09/30/12 with congestive heart failure tus, and chronic obstructive			accurately onto the MAR completed b 8/12/16.	-		
	dated 04/07/16 revea	ly Minimum Data Set (MDS) led Resident #19 was received a diuretic daily			The SF in-serviced all licensed nurses 8/12/16 on the correct transcription of physician telephone orders and mont MAR review. No licensed nurses wer permitted to work until they received t in-service and newly hired licensed st will receive the in-service by the SF d	hly re his aff		
	Review of a progress note dated 05/20/16 revealed Resident #19 was seen by the Nurse Practitioner (NP) due to weight gain. Resident #19 reported increased edema in both her lower legs. The NP noted the plan was to increase Resident #19's Lasix (a diuretic) to 60 mg (milligrams) daily. Review of the medical record revealed an order				orientation. An audit tool will be utilized each nigh the third shift nursing staff to review 1 of all physician telephone orders to ve correct transcription of orders to the N The DON, MDS Coordinator or SF wi re-check physician telephone orders Monday thru Friday for accuracy of	t by 00% erify 1AR. II		
		05/20/16 to increase to 60 mg by mouth every e order was signed off by			physician telephone orders to the MA Re-training will be provided for any er identified by the DON, SF or MDS			

Facility ID: 923027

If continuation sheet Page 16 of 29

		MEDICAID SERVICES					<u>). 0938-03</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	SURVEY
				- °			С
		345219	B. WING				21/2016
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	1 017	
				10	07 MAGNOLIA DRIVE		
MAGNOLI	A LANE NURSING AND	REHABILITATION CENTER		M	ORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 281	Continued From page	e 16	F 28	81			
	Nurse #4 on 05/20/16		1 20	"	Coordinator. These audits will continu	۵	
		<del>.</del>			indefinitely.	~	
		19's Physician's orders for			-		
		of 2016 revealed Lasix 40			The DON, MDS Coordinator and/or SF	=	
	mg was prescribed e			will review new monthly MAR's,			
	Further review of the			comparing them to physician telephon	е		
		e #1 did not transcribe the sident #19's Lasix to 60 mg			orders, to verify accurate transcription onto the MAR each month with MD		
		he completed the month to			review.		
		of orders on 05/27/16.					
					The audit tools will be reviewed by the		
		19's May 2016 Medication			Executive QI Committee monthly for		
		d (MAR) revealed nurses			identification of potential trends and		
		m 05/01/16 through 05/31/16			development of plans of action to		
		dministered Lasix 40 mg by J. Further review of the May			determine the need for continued monitoring.		
		the order to increase Lasix to			monitoring.		
		was not transcribed to the					
	MAR by Nurse #4 on						
	Review of the June 2	016 MAR revealed Resident					
		d Lasix 40 mg every morning					
	from 06/01/16 throug	<b>č</b> , <b>č</b>					
	Poviow of the July 20	016 MAR revealed Resident					
	-	d Lasix 40 mg every morning					
	from 07/01/16 throug	<b>v</b> , v					
	An interview with Nur	rse #1 on 07/20/16 at 10:17					
		e completed the month to					
		of Physician's orders he					
		e current months MAR to					
		viewed the medical record					
	-	ders written for the resident					
	since the last review.						
		2016 Physician's orders and ted the review on 05/27/16.					
		hould have crossed out the					
	order for Lasix 40 mg						

If continuation sheet Page 17 of 29

	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	IO. 0938-039 E SURVEY IPLETED	
	CONTECTION	IDENTIFICATION NOWDER.	A. BUILDING	3		C	
		345219	B. WING		07/21/2016		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
MAGNOL	IA LANE NURSING AND	REHABILITATION CENTER		107 MAGNOLIA DRIVE MORGANTON, NC 28655			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 281	1 Continued From page 17 2016 MAR and transcribed the order for Lasix 60 mg every morning to the June 2016 MAR per the order written on 05/20/16. Nurse #1 indicated he must not have seen the order to increase Resident #19's Lasix to 60 mg when he completed the reconciliation. An interview was conducted with the Director of Nursing (DON) on 07/20/16 at 10:23 AM. The DON stated the nurses on the hall typically signed off the Physician's orders and were expected to sign and date orders, fax a copy of medication orders to the pharmacy, and transcribe the medication to the residents' current MAR. The DON confirmed Nurse #4 signed off the Physician's order on 05/20/16 for Resident #19's Lasix to be increased to 60 mg by mouth every morning. The DON further stated she could not explain how this medication error occurred because Nurse #4 was no longer employed by the facility. The interview further revealed the DON would have expected Nurse #1 to catch the omission of the order for Lasix 60 mg daily dated 05/20/16 when he completed the reconciliation of		F 28				
	orders and MARs on An interview with the revealed she expecte when she writes then increased Resident # because she reported her lower legs. The I #19 did not suffer any result of not receiving Lasix.	NP on 07/20/16 at 10:41 AM ed orders to be carried out n. The NP stated she 19's daily Lasix on 05/20/16 d increased edema in both NP further stated Resident y negative outcome as a g the increased dose of					

If continuation sheet Page 18 of 29

		ND HUMAN SERVICES			FO	ED: 08/22/20 RM APPROVE	
TATEMENT (	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>	IPLE CONSTRUCTION	(X3) DA	NO. 0938-03 TE SURVEY MPLETED	
		345219	B. WING _		C 07/21/2016		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
			107 MAGNOLIA DRIVE				
MAGNOLI	A LANE NURSING AND	REHABILITATION CENTER		MORGANTON, NC 28655			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CORRECTION ON SHOULD BE HE APPROPRIATE Y)	(X5) COMPLETIO DATE		
F 281	Continued From non	- 10					
F 201	Continued From page		F 2	81			
		signed off and dated the					
		of the order to the pharmacy, order to the residents' MAR.					
	Nurse #4 further state						
		lity and did not recall signing					
		r for Resident #19 on					
	05/20/16.						
F 333	483.25(m)(2) RESIDI	ENTS FREE OF	F 3	33		8/18/16	
SS=D	SIGNIFICANT MED I	ERRORS					
	The facility must one	ure that residents are free of					
	any significant medic						
	This REQUIREMENT	⊺ is not met as evidenced					
	-	iews and staff and nurse		Resident #19 had an order	for Lasix		
	practitioner interviews			60mg every morning correct			
	•	sed dose of diuretic ordered		to the Medication Administr	•		
	for edema by the Nur	se Practitioner for 1 of 5		(MAR) on 7/21/16 by the Di	rector of		
		or unnecessary medication		Nursing (DON)			
	use (Resident # 19).			Using an audit tool, the Sta	ff Eacilitator		
	The findings included	l:		(SF) and Director of Nursing			
				audited 100% of our active			
	Resident #19 was ad	mitted on 09/30/12 with		verify that all physician tele			
	0 0	congestive heart failure		written in the past three (3)			
		itus, and chronic obstructive		(May/June/July) were trans			
	pulmonary disease (0	JOPD).		accurately onto the MAR co 8/12/16.	ompleted by		
		rly Minimum Data Set (MDS)					
		lled Resident #19 was		The SF in-serviced all licen			
	• •	received a diuretic daily		8/12/16 on the correct trans			
	during the 7 day revie	ew perioa.		physician telephone orders MAR review. No licensed r			
	Review of a progress	note dated 05/20/16		permitted to work until they			
		9 was seen by the Nurse		in-service and newly hired I			
	Practitioner (NP) due			will receive the in-service d			

Facility ID: 923027

If continuation sheet Page 19 of 29

		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 08/22/2016 RM APPROVED NO. 0938-0391	
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345219	B. WING _				C 07/21/2016	
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
MAGNOLI	A LANE NURSING AND	REHABILITATION CENTER			07 MAGNOLIA DRIVE			
				м	IORGANTON, NC 28655			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 333	Continued From page	<b>-</b> 10	F 3	33				
	#19 reported increase	ed edema in both her lower he plan was to increase		,00	orientation by the SF.			
	Resident #19's Lasix (milligrams) daily.	(a diuretic) to 60 mg			An audit tool will be utilized each nigh the third shift nursing staff to review 1 of all physician telephone orders writte	00% en to		
	written by the NP on Resident #19's Lasix	to 60 mg by mouth every			ensure transcription accuracy onto the MAR. The DON, SF or MDS Coordin will review physician telephone orders	ator		
	morning for CHF. Th Nurse #4 on 05/20/16	e order was signed off by 5.			Monday thru Friday to ensure that physician telephone orders have been transcribed accurately onto the MAR.			
		note dated 05/26/16 9 was seen by the NP for a nt increase in Lasix. The NP			SF will provide retraining for errors identified.			
	continue the Lasix 60	l improved and planned to mg every morning and o's kidney function and			The audit tools will be reviewed month by the Executive QI Committee for identification of potential trends and development of plans of action to determine the need for continued	ıly		
	May, June, and July of mg was prescribed ev Further review of the orders revealed Nurs order to increase Res every morning when	19's Physician's orders for of 2016 revealed Lasix 40 very morning for CHF. June 2016 Physician's e #1 did not transcribe the sident #19's Lasix to 60 mg he completed the month to of orders on 05/27/16.	determine the need for continue monitoring.					
	Administration Recom- initialed the MAR from indicating they had ad- mouth every morning 2016 MAR revealed t	19's May 2016 Medication d (MAR) revealed nurses n 05/01/16 through 05/31/16 dministered Lasix 40 mg by . Further review of the May the order to increase Lasix to was not transcribed to the 05/20/16.						
		016 MAR revealed Resident d Lasix 40 mg every morning						

If continuation sheet Page 20 of 29

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE		
		345219	B. WING_				C 21/2016	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
				1	07 MAGNOLIA DRIVE			
MAGNOLI	A LANE NURSING AND	REHABILITATION CENTER		N	IORGANTON, NC 28655			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ULD BE COMPLET		
F 333	from 06/01/16 through Review of the July 20 #19 was administered from 07/01/16 through An interview with Nur AM revealed when he month reconciliation of typically compared th the new MAR and rev for any medication or since the last review. Resident #19's June confirmed he complet Nurse #1 stated he sl order for Lasix 40 mg 2016 MAR and transf mg every morning to order written on 05/20 must not have seen th Resident #19's Lasix completed the recond An interview was con Nursing (DON) on 07 DON stated the nurse off the Physician's ord sign and date orders, orders to the pharma medication to the resi DON confirmed Nurse Physician's order on 0 Lasix to be increased morning. The DON for explain how this med	h 06/30/16. 16 MAR revealed Resident d Lasix 40 mg every morning h 07/20/16. se #1 on 07/20/16 at 10:17 e completed the month to of Physician's orders he e current months MAR to viewed the medical record ders written for the resident Nurse #1 reviewed 2016 Physician's orders and ted the review on 05/27/16. hould have crossed out the on Resident #19's June cribed the order for Lasix 60 the June 2016 MAR per the D/16. Nurse #1 indicated he he order to increase to 60 mg when he ciliation. ducted with the Director of /20/16 at 10:23 AM. The es on the hall typically signed ders and were expected to fax a copy of medication cy, and transcribe the idents' current MAR. The e #4 signed off the 05/20/16 for Resident #19's to 60 mg by mouth every urther stated she could not ication error occurred	F	333	DEFICIENCY)			
	the facility. The interv	as no longer employed by view further revealed the ected Nurse #1 to catch the						

Facility ID: 923027

If continuation sheet Page 21 of 29

		ID HUMAN SERVICES MEDICAID SERVICES				F	TED: 08/22/2016 ORM APPROVED NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	IPLE CONSTRUCTI		(X3) E	DATE SURVEY OMPLETED
		345219	B. WING				C 07/21/2016
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRE	SS, CITY, STATE, ZIP CODE		
MAGNOLI	A LANE NURSING AND	REHABILITATION CENTER		107 MAGNOLIA DRIVE			
				MORGANTON	N, NC 28655		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECTION       (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX     (EACH CORRECTIVE ACTION SHOULD BE       REGULATORY OR LSC IDENTIFYING INFORMATION)     TAG     CROSS-REFERENCED TO THE APPROPRIATE			(X5) COMPLETION DATE			
F 333	05/20/16 when he con Resident #19's May a orders and MARs on An interview with the revealed she expected when she writes them increased Resident # because she reported her lower legs. The N #19 did not suffer any result of not receiving and noted Resident # despite not receiving During a telephone in PM Nurse #4 stated v medication order she order, faxed a copy o and transcribed the o Nurse #4 further state employed by the facil off a medication order 05/20/16.	for Lasix 60 mg daily dated mpleted the reconciliation of and June of 2016 Physician's 05/27/16. NP on 07/20/16 at 10:41 AM ed orders to be carried out n. The NP stated she 19's daily Lasix on 05/20/16 d increased edema in both NP further stated Resident y negative outcome as a g the increased dose of Lasix 419's edema had decreased the increased dose. Atterview on 07/20/16 at 2:35 when she received a signed off and dated the f the order to the pharmacy, rder to the residents' MAR. ed she was no longer ity and did not recall signing r for Resident #19 on	F	333			
F 431 SS=E	revealed she could no her lower legs had de	9 stated she always had egs. RUG RECORDS,	F 4	131			8/18/16
	a licensed pharmacis of records of receipt a	loy or obtain the services of t who establishes a system and disposition of all ifficient detail to enable an					

Facility ID: 923027

If continuation sheet Page 22 of 29

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/22/2016 APPROVED D. 0938-0391	
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345219	B. WING				21/2016	
	ROVIDER OR SUPPLIER A LANE NURSING AND	REHABILITATION CENTER	I	1	TREET ADDRESS, CITY, STATE, ZIP CODE 07 MAGNOLIA DRIVE MORGANTON, NC 28655	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 431	records are in order a controlled drugs is ma reconciled. Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the applicable. In accordance with Si facility must store all locked compartments controls, and permit of have access to the ke The facility must prov permanently affixed of controlled drugs listed Comprehensive Drug Control Act of 1976 a abuse, except when the package drug distribu- quantity stored is min- be readily detected. This REQUIREMENT by: Based on observatio facility failed to moniti- temperatures of media	<ul> <li>and that an account of all aintained and periodically</li> <li>a used in the facility must be evith currently accepted s, and include the y and cautionary expiration date when</li> <li>tate and Federal laws, the drugs and biologicals in a under proper temperature only authorized personnel to eys.</li> <li>ride separately locked, compartments for storage of d in Schedule II of the Abuse Prevention and nd other drugs subject to the facility uses single unit ution systems in which the simal and a missing dose can</li> <li>T is not met as evidenced an and staff interviews, the or safe storage</li> </ul>	F	431	On 7/20/16, all medications were removed and discarded from the brow refrigerator designated for medication storage at the Central Hall Medication			
	The facility also failed not receive potentially	I to ensure residents would y ineffective medications as of date medications in 2 of 2			Room by the Director of Nursing (DON All expired medications or supplements and medications or supplements dated	I). s		

Facility ID: 923027

If continuation sheet Page 23 of 29

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345219	B. WING _				C 21/2016	
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
				10	7 MAGNOLIA DRIVE			
MAGNOLI	A LANE NURSING AND	REHABILITATION CENTER		M	ORGANTON, NC 28655			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EA			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 431	storage room for the of The brown refrigerators storage had a thermood degrees. There was temperatures for January available. Paper logs temperatures were or Nurse # 1 and the Min Nurse were asked wh temperatures of the refrigerators of the refrigerators MDS Nurse said that responsible for monitor the refrigerator. They know where the docu a. Medications store temperatures had not 28 Tylenol 650 mg su unopened) 55 25mg suppositories (suppositories unoper 1 Insulin Humalog 10 (unopened) 1 10 ml vial Novolog II (unopened) 1 Tuberculin Purified date 6/30/16. 10 test (5 US units per test) 1 Tuberculin purified for 7/11/16, appeared to vial1 10 ml Vial Lantur (unopened) 2 vial Lantus insulin 1 7/15/16	boms. 0:30 AM the medication Central Hall was observed. or designated for medication meter inside which read 35 not a log of recorded daily uary through current date a for 2015 with recorded n top of the refrigerator. nimum Data Set (MDS) no monitored the efrigerator, and where the corded. Nurse #1 and the the third shift nurse was oring the temperatures of v also stated they didn't mentation was to be kept. ed in the refrigerator where a been recorded included uppositories (suppositories es (in plastic zip lock bag) ned) 0 units/1 ml Qwik pen Insulin, 100 units/1 ml Protein Derivative, open vial appeared to be half full protein derivative open date have one dose remaining in us insulin 100units/1ml 00 units/1ml both opened	F 4	431	but past the time frame noted by the manufacturer found in the Central Hall Main Hall Medication Storage rooms w discarded by the DON on 7/20/16. Medications of discharged residents observed in the Central Hall or Main Ha Medication Storage rooms were returned to the pharmacy by the DON on 7/21/1 Temperatures of the refrigerators were checked in the Central(35 degrees) and Main Hall(37 degrees) Medication Stora rooms by the DON. On 7/21/16, the Staff Facilitator (SF) inspected the Central Hall Medication Storage room, the Main Hall Medication Storage room and the Medication carts for any expired medications, medication or supplements dated but past the designated time frame noted by the manufacturer and medications belongin to discharged residents. Any medication found to be expired or belonging to discharged residents were returned to pharmacy. Temperature logs were plat on each refrigerator located in the Cent and Main Medication Storage rooms by the SF for documentation of daily temperatures to be recorded by license staff daily.	ere all ed 6. d age n (2) ns ng ons the ced tral / ed sed of ge,		
		00 units / 1ml (unopened)			temperatures of medications requiring refrigeration and documentation of dail	y		

Event ID: 63TY11

Facility ID: 923027

If continuation sheet Page 24 of 29

ITATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         IND PLAN OF CORRECTION       (X1) IDENTIFICATION NUMBER:         345219         NAME OF PROVIDER OR SUPPLIER		. ,	(X3) DATE	(X3) DATE SURVEY COMPLETED		
		A. BUILDING			C	
		B. WING	07/21/2016			
			STREET ADDRESS, CITY, STATE, ZIP CODE	DDE		
MAGNOLIA LANE NURSING AND REHABILITATION CENTER			107 MAGNOLIA DRIVE MORGANTON, NC 28655			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	LD BE	(X5) COMPLETIO DATE	
Continued From page	24	F 43	1			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 24 1 10 ml vial Levemir 100units/1ml opened 7/16/16 11 10 ml vials Levemir 100units/1ml unopened On July 20, 2016 the medications that were observed in medication storage room which were past the expiration dates included: 31 Heparin 5 ml prefilled syringes (100units/ml) Expiration date 1/2016 17 Heparin 5 ml prefilled syringes (100units/ml) Expiration date 6/2017 Influenza Vaccine Fluzone High Dose, unopened10 prefilled syringes (0.5ml each) expiration date 12 June 2016; Influenza Vaccine Fluzone High Dose, (0.5ml each) opened box 6 syringes expiration date 12 June 2016 Influenza Virus Vaccine Fluvirin 2015-2016 formula Expiration date 5/20/16, 2 unopened vials An opened bottle for liquid EryPed 200 (erythromycin ethysuccinate for oral suspension 200 mg per 5 ml) was labeled as opened on 4/19/16. The label instructions stated medication was to be used within 35 days of being opened. The prescription was for a resident who remained in the facility. b. In the Medication Storage Room on Central Hall medications prescribed for discharged resident observed to be on shelf in cabinet on 7/20/16. The resident had been in the facility from April 14 through April 16, 2016. The medications observed included an opened box of Sodium Chloride 9% 10 ml prefilled syringes which contained 20 out of 30 dispensed syringes. There were Heparin Flush 5 ml prefilled syringes			<ul> <li>licensed nurses will receive the in-seregarding Medication storage and Iduring orientation by the SF.</li> <li>Utilizing an audit tool, the DON, SF MDS Coordinator will inspect the C and Main Hall Medication Storage I and medications carts (2) weekly x weeks then monthly indefinitely for expired medications, undated medications, medications belonging discharged residents and medications/supplements dated but the time frame recommended by the manufacturer. The temperature log be reviewed weekly x 4 weeks ther monthly indefinitely by the DON, SF MDS Coordinator to ensure refriger are kept within appropriate range w daily temperature documentation completed.</li> <li>The audit tools will be reviewed monthly the Executive QI Committee for the series of the</li></ul>	service abeling or entral Rooms 4 g to t past e gs will f or rators vith		
	S FOR MEDICARE & OF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER IA LANE NURSING AND SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page 1 10 ml vial Levemin 1 10 ml vials Levemin On July 20, 2016 the observed in medication past the expiration date 31 Heparin 5 ml prefil Expiration date 1/201 17 Heparin 5 ml prefil Expiration date 6/201 Influenza Vaccine Flu unopened10 prefilled expiration date 12 Jul Influenza Vaccine Flu unopened box 6 s June 2016 Influenza Virus Vaccin formula Expiration dat An opened bottle for (erythromycin ethysu 200 mg per 5 ml) was 4/19/16. The label in was to be used within The prescription was in the facility. b. In the Medication Hall medications press resident observed to 7/20/16. The residen from April 14 through medications observed Sodium Chloride 9% which contained 20 o There were Heparin F with 10 units/ml obse shelf in medication car remaining syringes of	SFOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES FORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         Addata       345219         ROVIDER OR SUPPLIER       345219         ROVIDER OR SUPPLIER       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 24       1 10 ml vial Levemir 100units/1ml unopened 7/16/16         11 10 ml vial Levemir 100units/1ml unopened       On July 20, 2016 the medications that were observed in medication storage room which were past the expiration dates included: 31 Heparin 5 ml prefilled syringes (100units/ml)         Expiration date 1/2016       17 Heparin 5 ml prefilled syringes (100units/ml)         Expiration date 6/2017       Influenza Vaccine Fluzone High Dose, unopened10 prefilled syringes (0.5ml each) expiration date 12 June 2016; Influenza Vaccine Fluzone High Dose, (0.5ml each) opened box 6 syringes expiration date 12 June 2016         Influenza Virus Vaccine Fluzione stated medication was to be used within 35 days of being opened. An opened bottle for liquid EryPed 200 (erythromycin ethysuccinate for oral suspension 200 mg per 5 ml) was labeled as opened on 4/19/16. The label instructions stated medication was to be used within 35 days of being opened. The prescription was for a resident who remained in the facility.         b. In the Medication Storage Room on Central Hall medications prescribed for discharged resident observed to be on shelf in cabinet on 7/20/16. The resident had been in the facility from April 14 through April 16, 2016. The medications observed in linger Silled syringes whi	SPOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES         CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         A State         A LANE NURSING AND REHABILITATION CENTER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 24         1 10 ml vial Levemir 100units/1ml opened 7/16/16         111 10 ml vials Levemir 100units/1ml unopened         On July 20, 2016 the medications that were observed in medication storage room which were past the expiration dates included:         31 Heparin 5 ml prefilled syringes (100units/ml)         Expiration date 1/2016         17 Heparin 5 ml prefilled syringes (0.5ml each) expiration date 1/2016         Influenza Vaccine Fluzone High Dose, unopened 10 prefilled syringes (0.5ml each) opened box 6 syringes expiration date 12 June 2016         Influenza Virus Vaccine Fluzone High Dose, (0.5ml each) opened box 6 syringes expiration date 12 June 2016         Influenza Virus Vaccine Fluzone High Dose, (0.5ml each) opened box 6 syringes expiration date 12 June 2016         Influenza Virus Vaccine Fluzone High Dose, (0.5ml each) opened box 6 syringes expiration date 12 June 2016         Influenza Virus Vaccine Fluzone High Dose, (0.5ml each) opened box 6 syringes expiration date 12 June 2016         Influenza Virus Vaccine Fluzone High Dose, (0.5ml each) opened box 6 syringes of being opened. The prescription was for a resident who remaine	SFOR MEDICARE & MEDICAID SERVICES         OF DEFINICIENCIES       (11) PROVIDERSUPPLERCULA IDENTIFICATION NUMBER:       (22) MULTIFLE CONSTRUCTION A BUILDING         345219       B. WING         ROVIDER OR SUPPLIER       B. WING         IA LANE NURSING AND REHABILITATION CENTER       STREETADRESS, CITY, STATE, ZIP CODE 107 MAGNOLAD RRVE MORGANTON, NC 28655         IMMARY STATEMENT OF DEFICIENCIES (BCAH DEFICIENCY MUST BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D PROVIDER OR SUPPLIER         Continued From page 24       F 431         1 0 mi vials Levemir 100units/Tml opened 7/16/16       F 431         11 10 mi vials Levemir 100units/Tml opened 7/16/16       F 431         11 Hoparin 5 mi prefilled syringes (100units/mi) Expiration date 1/2016       F 431         17 Heparin 5 mi prefilled syringes (100units/mi) Expiration date 1/2016       F 431         Influenza Vaccine Fluxone High Dose, unopened Do Ko Syringes (0.5ml each) opened box 6 syringes expiration date 12 June 2016       F 431         Influenza Virus Vaccine Fluxone High Dose, 200 mg per 5 ml) was labeled as opened on resident observed in a size for oral suspension 200 mg per 5 ml) was labeled as opened on resident observed in the facility from April 14 through April 16, 2016. The medications prescribed for discharged resident observed in a opened box of Sodium Choide 9% 10 m Prefiled syringes which contained 20 out of 30 dispensed syringes. Whith 0 units/mi observed in an opened box of Sodium Choide 9% 10 m prefiled syringes whith 10 units/mi observed in an opened box on shef in medic	PCENCIENCIES       (N1) PROVIDER/SUPPLIERLATION NUMBER:       (P2) MUTHPLE CONSTRUCTION       (P2) MUT	

Facility ID: 923027

If continuation sheet Page 25 of 29

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					PRINTED: 08/22/201 FORM APPROVE OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED C		
	345219		B. WING		07/21/2016		
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC			
	A LANE NURSING AND	REHABILITATION CENTER		107 MAGNOLIA DRIVE			
		-		MORGANTON, NC 28655			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE COMPLETIC DATE DATE		
F 431	Continued From page	e 25	F 43	1			
		s/1ml for a previously	1 10				
		The prescription date for					
	the PosiFlush syringe						
	Twenty-eight syringes remained in a box that	s of Heparin PosiFlush					
		Storage room on the Main					
		n 7/20/2016 at 11:00 AM.					
		ation was observed. The					
		was a vial of Lorazepam for on with dose of 2 mg/ml. The					
	vial had expiration da	-					
	•	cribed for resident who					
		ty. Nurse # 3 was present					
	-	n of the Main Hall storage					
	out of date.	t the vial of Lorazepam was					
	-	AM and 11:10 AM an					
		cted with the Director of stated it was her expectation					
	- · ·	torage rooms be reviewed					
		d removed from medication					
		ions found to be out of date.					
		it was her expectation that ted for medication storage					
		and temperatures recorded					
	on written log to ensu	ire medications are stored at					
	proper temperatures.						
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMB	ERS/MEET	F 52	U	8/18/16		
33-D	QUARTERLY/PLANS						
		in a quality assessment and					
		e consisting of the director of					
	nursing services; a pl facility; and at least 3	hysician designated by the other members of the					

Facility ID: 923027

If continuation sheet Page 26 of 29

		ND HUMAN SERVICES			PRINTED: 08/2 FORM APPR OMB NO. 0938	ROVI	
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345219	B. WING		C 07/21/201	6	
AME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
IAGNOLI	A LANE NURSING AND	REHABILITATION CENTER		07 MAGNOLIA DRIVE IORGANTON, NC 28655			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE COMPI	(5) LETIC ATE	
F 520	Continued From page	e 26	F 520				
	issues with respect to and assurance activit develops and implem action to correct iden A State or the Secre disclosure of the reco except insofar as suc compliance of such o requirements of this s	east quarterly to identify b which quality assessment ties are necessary; and nents appropriate plans of tified quality deficiencies. tary may not require ords of such committee ch disclosure is related to the committee with the section. by the committee to identify eficiencies will not be used as					
	by: Based on record rev facility's Quality Asse Committee failed to r procedures and mon the committee put int October of 2015. This deficiencies which we September 2015 on a complaint survey and was cited in October complaint survey. Th areas of housekeepin services, Care Area A medication errors. Th three federal surveys	ere originally cited in a recertification and d 1 recited deficiency which 2015 on a follow up and e deficiencies were in the ng and maintenance Assessments and significant ne continued failure during of record show a pattern of to sustain an effective Quality		On 8/8/16, the facility Executive ( Committee held a meeting to inclu Medical Director, Administrator, D MDS Coordinator, SF, Maintenan Director, Housekeeping/Laundry Supervisor and Activity Director to determine attendees that will atten Executive QI Committee meetings on-going quarterly basis and then additional team members as appr On 8/8/16,the facility consultant in-serviced administrator, DON, M Coordinator, Medical Director, Maintenance Director, Dietary Ma SF, Activity Director, Housekeeping/Laundry Superviso	ude the PON, ce nd s on an assign opriate. IDS nager,		

Facility ID: 923027

If continuation sheet Page 27 of 29

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						PRINTED: 08/22/2016 FORM APPROVED OMB NO. 0938-0391		
				(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345219		B. WING	B. WING			C 7/21/2016	
NAME OF PR	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE			
				107 MA	GNOLIA DRIVE			
MAGNOLI	A LANE NURSING AND	REHABILITATION CENTER		MORGANTON, NC 28655				
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETIC DATE	
F 520	Continued From page	e 27	F 5	20				
				Re	ceivable Manager about the QA	PI		
	The findings included	1:			cess, appropriate function of th			
					mmittee, the purpose of the cor			
	Those tags are areas	referred to:			ntification of issues related to q sessment and assurance and	uality		
	These tags are cross				veloping/implementing appropri	ato		
	· F253 Housekeer	oing and Maintenance			ns of action for identified facility			
	-	was recited for F253 for			ncerns to include F253 Houseke			
	failing to label and pr			d Maintenance, F272 Care Area				
	hygiene products and	d resident care equipment on			sessments, F333 Significant			
	2 of 2 resident halls.				dication Errors and F 431 Drug			
	-	ally cited during a			cords, Label/Storage Drugs &			
		mplaint survey on 09/11/15		Bio	logicals.			
		dpans and bath basins with dent room #86, #87, #105		The	e Executive QI Sub-Committee.			
	-	lean a privacy curtain in a			dical Director, Administrator, D			
		n #99), failed to store lift			/ will begin monthly meetings to			
		the floor (receptionist area),			dit tools to determine the need f			
	failed to repair damage	ged handrails (main hall),		cha	anges to the audits, frequency o	of audits		
	-	molding (between resident			d need for continued monitoring			
		1, receptionist area and			icated related to F253, F272, F	278, F		
		tation on the main hall),		281	1, F333 and F 431.			
	•	n laminate on a cabinet			artarly the Degianal Vice Dreed	dont of		
	. ,	ed to repair broken areas of n smoke prevention doors			arterly, the Regional Vice Presi erations, the Vice President of			
	(100 hall).	n smoke prevention doors			rvices and the Facility Consulta			
	(100 Hall).				end and review the facility audit			
	· F272 Care Area	Assessments: The facility			d Executive QI Committee meet			
		for failing to complete Care			nutes to ensure systems are in	-		
		at addressed the underlying			event reoccurrence of non-comp			
	-	factors and risk factors for 5			h F253 Housekeeping & Mainte	enance		
		nts (Residents #50, #23, #1,			rvices, F272 Comprehensive			
	#44, #39).	ally sited during a			sessments, F278 Assessment	l to		
	-	ally cited during a mplaint survey on 09/11/15			curacy, F281 Services Provideo et Professional Standards, F33			
		e Care Area Assessments			sidents Free of Significant Med			
	that addressed the u				d F431 Drug Records, Label/St			
		nd risk factors for triggered			ugs & Biologicals x 1 year with			
	areas for 3 of 17 (Residents #25, #53, and #56)				raining provided as indicated.			

Facility ID: 923027

If continuation sheet Page 28 of 29

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 08/22/2016 // APPROVED ). 0938-0391		
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		345219	B. WING			-	C 07/21/2016			
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STA	ATE, ZIP CODE				
MAGNOL	A LANE NURSING AND	REHABILITATION CENTER			107 MAGNOLIA DRIVE MORGANTON, NC 2865	5				
(X4) ID PREFIX TAG			ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE		
F 520	<ul> <li>sampled residents.</li> <li>F333 Significant Medication Error: The facility was recited for F333 for failing to administer an increased dose of diuretic ordered for edema by the Nurse Practitioner for 1 of 5 residents reviewed for unnecessary medication use (Resident # 19).</li> <li>F333 was originally cited during a follow up</li> </ul>		F	520						

If continuation sheet Page 29 of 29