STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242 SS=E	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and resident, staff, and family interviews the facility failed to honor a request by a responsible party to elevate the head of the bed (Resident #7), provide residents' their preferred number of showers every week (Resident #7, #20, #35, #59 #78), and did not honor food preferences (Resident #79) for 6 of 7 residents reviewed for choices. The findings included: 1. a. Resident #7 was admitted on 11/30/11 with diagnoses including dementia, pneumonia, and a history of pneumonitis due to the inhalation of food and vomit. Review of a quarterly Minimum Data Set (MDS) dated 07/05/17 revealed Resident #7 had severely impaired cognitive skills for daily	F 242	Magnolia Lane Nursing and Rehabilitation Center acknowledges receipt of this statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance. Magnolia Lane Nursing and Rehabilitation Center's response to this statement of deficiencies does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Magnolia Lane Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this statement of	10/6/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/30/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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F 242	Continued From page 1 decision making and was able to make her needs known. No rejection of care was observed during the 7 day assessment period. An initial observation of Resident #7 on 09/05/17 at 11:20 AM revealed she was resting in bed and the head of the bed was elevated 45 degrees. There was a hand written sign over the bed which stated, "Keep the head of the bed elevated 45 degrees at all times." During an interview on 09/05/17 at 12:31 PM Resident #7's Responsible Party (RP) stated he had asked staff several times for the head of her bed to be elevated at all times due to recent pneumonia and frequently found her without the head of the bed elevated. An interview was conducted with Nurse Aide (NA) #3 on 09/06/17 at 4:58 PM who was assigned to the resident at that time. NA #3 stated Resident #7 had pneumonia recently and did not breathe well when the head of the bed was flat. NA #3 indicated they were supposed to keep the head of Resident #7's elevated. Subsequent observations of Resident #7 revealed the following: - On 09/06/17 at 11:09 AM and 3:33 PM Resident #7 was resting in bed with the head of the bed elevated approximately 3 inches. - On 09/07/17 at 11:10 AM Resident #7 was awake in bed with the head of the bed elevated 45 degrees. - On 09/08/17 at 10:01 AM Resident #7 was resting in bed with her eyes closed with the bed flat. An interview with the Director of Nursing (DON)	F 242	deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding. F 242 The position of Magnolia Lane Nursing and Rehabilitation Center regarding the process that lead to this deficiency was the staff had a knowledge deficit related to the resident/responsible party had the right to make choices about the aspects of his/her life in the facility that are significant to the resident/responsible party. On 9/8/17, 9/9/17 and 9/10/17, resident #7 was observed by the Administrator and Director of Nursing in bed with the head of bed elevated 45 degrees as requested by the responsible party. On 9/9/17, residents #7, 20, 35, 59 and 78 received showers by the certified nursing assistants as requested. On 9/14/17, residents #7, 20, 35, 59 and 78 or their responsible parties were interviewed by a registered nurse to determine bathing preferences to include type, time of day and frequency of bathing desired. On 9/11/17, resident #79 was interviewed by the Dietary Manager to update his likes/dislikes. Dislikes included gravy and beans. Observations of resident #79 meals from 9/9/17-9/16/17 resulted in resident #79 receiving no foods/drinks he disliked. Resident #79 was educated on	

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	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

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F 242	Continued From page 2 on 09/07/17 at 2:58 PM revealed Resident #7's RP had put the sign over the bed for the head of the bed to be elevated 45 degrees and there was no Physician's order for this. During an interview on 09/08/17 at 10:14 AM the Physician stated keeping the head of the bed elevated was not proven to prevent aspiration but it would be wise to do this if Resident #7's RP had requested. An interview was conducted with the Administrator on 09/08/17 at 2:05 PM. The Administrator recalled Resident #7's RP spoke with her sometime back in April of 2017 and requested the head of her bed be elevated 45 degrees at all times. The Administrator indicated Resident #7's RP had put the sign over her bed. The Administrator stated the facility tried to be respectful of family member's wishes and she had tried to educate staff about elevating the head of Resident #7's bed but there had been a lot of staff turnover. b. Resident #7 was admitted on 11/30/11 with diagnoses including dementia. Review of a quarterly Minimum Data Set (MDS) dated 07/05/17 revealed Resident #7 had severely impaired cognitive skills for daily decision making and was able to make her needs known. She was totally dependent on staff with bathing. Review of a care plan for activities of daily living revised on 06/23/17 revealed Resident #7 required assistance with bathing related to her cognitive impairment, impaired mobility, and physical limitations. Interventions included total	F 242	the need to report to the nursing staff any time he received meals or foods he disliked or the desire to receive an alternative meal. On 9/27/17, an interview with all current resident or responsible parties was completed by the Administrator, Director of Nursing and Dietary Manager related to preference on head of bed positioning, bathing preference and dietary likes/dislikes. The MDS nurse updated any changes to the care plan and resident care guide as indicated. On 9/18/17, 100% of nursing staff were in-serviced by the Director of Nursing regarding the preference of resident #7's responsible party to keep resident #7's head of bed elevated 45 degrees at all times. On 9/20/17, the Director of Nursing developed a new shower schedule reflecting the bathing preference of each resident or responsible party to include bath type, frequency and time of day. 100% of nursing staff were in-serviced by 9/29/17 by the Director of Nursing regarding the new shower schedule and the need to report any requested changes for updates. The Dietary staff received an in-service on 9/20/17 by the Dietary Manager regarding the need to follow the dietary tray cards in reference to resident likes/dislikes. The Dietary Manager will highlight the dislikes list on the tray cards to improve visibility of	

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	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 242	Continued From page 3 dependence on one person with bathing and the resident preferred showers 3 times a week. Review of the shower schedule revealed Resident #7 was scheduled to receive showers every Wednesday and Saturday during the 1st shift (7:00 AM to 3:00 PM). During an interview on 09/05/17 at 12:19 PM Resident #7's Responsible Party stated she received 2 showers a week but he would like for her to have three a week. The family member did not recall anyone ever asking how many showers Resident #7 preferred weekly. An interview conducted on 09/07/17 at 2:46 PM with the Social Worker (SW) revealed when a resident was admitted to the facility she informed them or their responsible party they would receive two showers per week. She stated a resident could have more than two showers per week but they had to ask for them. She stated she wasn't aware of any facility staff asking the residents for their shower preferences. During an interview on 09/08/17 at 2:05 PM the Director of Nursing (DON) stated she was not sure what system the facility had in place for assessing residents' preference regarding how many showers they wanted every week. The DON further stated if Resident #7 had requested and was care planned for 3 showers every week she should be scheduled for 3 showers a week. An interview with the Administrator on 09/08/17 at 5:25 PM revealed the facility should revisit choices for showers for all residents and also provide residents with the number of showers specified on their plan of care.	F 242	the dislikes list on each tray card to prevent residents from receiving foods/drinks they do not like. The charge nurse assigned to care for resident #7 will monitor and document each shift to ensure that the head of bed is elevated 45 degrees at all times on the Medication Administration Record (MAR). The Director of Nursing and Staff Facilitator, using an audit tool, will monitor showers given daily to ensure residents are receiving showers per the resident or responsible party preference. Using an audit tool, the Dietary Manager will review 10% of served meals x 4 weeks to ensure residents do not receive foods/drinks they do not like. The audit tools will be reviewed at the monthly Executive QI Committee meeting to ensure the facility maintains implemented procedures and monitors these interventions for continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

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F 242	Continued From page 4	F 242		

2. Resident #78 was admitted to the facility on 06/01/17 with diagnoses of a fractured ankle, chronic kidney disease, hypertension and diabetes.

The admission Minimum Data Set (MDS) dated 06/14/17 coded her with a brief interview for mental status score of an 11 out of 15 indicating moderately impaired cognition.

The quarterly MDS dated 08/26/17 showed she had no cognitive impairments.

On 09/05/17 at 11:38 AM, Resident #78 stated during an interview that she was not given a choice as to how many showers or baths she would like each week. She stated they scheduled two showers per week and she does not always get 2 showers per week. Ideally she stated she would want a shower daily.

During follow up interview on 09/07/17 at 11:58 AM, Resident #78 she stated she only received one shower a week and didn't think there was enough staff.

Review of the shower documentation revealed since 07/01/17 she received a shower as follows:
a. 3 in July 2017 on 07/02/17, 07/07/17 and 07/15/17;
b. 2 in August 2017 on 08/08/17, 08/11/17 and she was on the list for 08/29/17 but no initials or note indicating the shower was provided;
c. in September 2017 she was showered on 09/01/17 and again on the list for 09/04/17 but no initials to document that a shower was offered and or given.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

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F 242	Continued From page 5	F 242		

Interview with the Social Worker/Admissions Director on 09/07/17 at 2:45 PM revealed during the admission process, she generalized the shower schedule and explained the schedule was set up for 2 showers per week and the days depended on the room the resident was in. She stated she gave the schedule the resident would be on. She stated that she thought nursing would ask the resident preferences during admission or that the resident would speak up if they wanted a different schedule. The interview further revealed residents could have more than 2 showers a week and they should request such.

On 09/08/17 at 2:35 PM the Director of Nursing stated that she was aware that residents were not getting their showers consistently. She stated the facility was having some staffing issues. She further stated that if a resident refused a shower, the nurse aide was to get the nurse to assist. She stated she reconfigured the sheets to ensure each staff knew the schedule and if there was no documentation on the shower sheet, the shower was probably not given. In addition, it was her understanding that the Social Worker would obtain a residents' choice regarding the number of showered they wanted while at the facility. She did not expect nursing to obtain that information.

The Administrator stated on 09/08/17 at 5:07 PM during interview that she thought the Social Worker reviewed resident choices. She stated there was a schedule which would accommodate residents' voiced preferences.

3. Resident #20 was admitted to the facility on 09/06/13 with diagnoses including dysphagia, chronic pain, heart failure, chronic respiratory failure, chronic obstructive pulmonary disease,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 6	F 242		

and hemiplegia.

His annual Minimum Data Set dated 07/08/17 coded him with having intact cognition.

Resident #20 stated on 09/05/17 at 11:15 AM during interview that he does not have a choice as to how many showers he gets per week. Resident #20 stated that he would prefer a shower every day and that would never happen. He then stated they asked him his choices but they definitely do not follow wishes mainly because there was not enough staff. He stated he was promised 2 showers per week and only gets 2 showers a week "once in a great while."

Review of the shower documentation since 07/01/17 revealed:
a. In July 2017 he received a shower on 07/02/17 and 07/15/17;
b. In August 2017 he was showered on 08/08/17, was scheduled for 08/11/17 but no initials were next to his name to indicate he was offered or given a shower; he refused a shower on 08/14/17; and he was showered on 08/18/17 and 08/30/17.

Although no shower sheets were provided for September 2017, he was observed coming out of the shower on 09/06/17 at 4:00 PM.

Interview with the Social Worker/Admissions Director on 09/07/17 at 2:45 PM revealed during the admission process, she generalized the shower schedule and explained the schedule was set up for 2 showers per week and the days depended on the room the resident was in. She stated she gave the schedule the resident would be on. She stated that she thought nursing would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 242	Continued From page 7	F 242		

ask the resident preferences during admission or that the resident would speak up if they wanted a different schedule. The interview further revealed residents could have more than 2 showers a week and they should request such.

On 09/08/17 at 2:35 PM the Director of Nursing stated that she was aware that residents were not getting their showers consistently. She stated the facility was having some staffing issues. She further stated that if a resident refused a shower, the nurse aide was to get the nurse to assist. She stated she reconfigured the sheets to ensure each staff knew the schedule and if there was no documentation on the shower sheet, the shower was probably not given. In addition, it was her understanding that the Social Worker would obtain a residents' choice regarding the number of showered they wanted while at the facility. She did not expect nursing to obtain that information.

The Administrator stated on 09/08/17 at 5:07 PM during interview that she thought the Social Worker reviewed resident choices. She stated there was a schedule which would accommodate residents' voiced preferences.

4. Resident #59 was most recently admitted on 01/13/17 with diagnoses of dysphagia, diabetes, peripheral vascular disease and cerebral infarction.

Her last three quarterly Minimum Data Sets dated 01/20/17, 04/19/17 and 07/13/17 coded her as having intact cognition and no behaviors.

During an interview on 09/07/17 at 12:02 PM, Resident #59 stated that the 2 showers scheduled per week was fine with her, however,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 8	F 242		

she stated that she does not get 2 showers a week. She stated that she did not get a shower last week and no shower thus far this week. Resident #59 indicated sometimes staff would explain that there was only one nurse aide on and then they expect the next shift to pick up missed showers. She further stated that you can complain all you want but it had done no good so she quit complaining and tried to clean herself the best she can.

Review of shower documentation from 07/01/17 revealed Resident #59 received the following showers:
a. in July 2017 she was showered on 07/15/17;
b. in August 2017 she was showered 08/09/17, 08/11/17, on 08/18/17 her name was on the shower list but no initials to indicate she received a shower; she received showers on 08/22/17 and 08/29/17;
c. in September 2017 she was on the list for 09/01/17 but there was no initials to indicate she was offered or given a shower.

On 09/08/17 at 2:35 PM the Director of Nursing stated that she was aware that residents were not getting their showers consistently. She stated the facility was having some staffing issues. She further stated that if a resident refused a shower, the nurse aide was to get the nurse to assist. She stated she reconfigured the sheets to ensure each staff knew the schedule and if there was no documentation on the shower sheet, the shower was probably not given. In addition, it was her understanding that the Social Worker would obtain a residents' choice regarding the number of showered they wanted while at the facility. She did not expect nursing to obtain that information.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 9	F 242		

The Administrator stated on 09/08/17 at 5:07 PM during interview that she thought the Social Worker reviewed resident choices. She stated there was a schedule which would accommodate residents' voiced preferences.

5. Resident #35 was admitted to the facility on 03/12/11 with current diagnoses of paraplegia and traumatic brain injury.

Review of the quarterly Minimum Data Set (MDS) dated 07/10/17 revealed Resident #35 was moderately cognitively impaired and required extensive assistance for personal hygiene and bathing.

Review of the care plan dated 07/18/17 revealed Resident #35 required assistance with bathing related to impaired mobility, physical limitations (refuses baths at times). The goal was for Resident #35 to be neat, clean and odor free through the next review. The interventions included: one person to provide physical assist for bathing. Encourage resident to participate in self-care as ability permits. Prefers showers three times a week.

Review of the facility shower schedules from 07/2016 to present revealed Resident #35 received one to two showers per week with no documented refusal of shower's.

Observations made of Resident #35 on 09/06/17 at 12:02 PM, 09/07/17 at 8:11 AM and 09/08/17 at 2:25 PM revealed he was clean with no odors.

An interview conducted on 09/05/17 at 2:49 PM with Resident #35 revealed he wanted more showers per week than he was receiving.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 10	F 242		

Resident #35 stated he was supposed to receive three showers per week and some weeks he only received one.

An interview conducted on 09/07/17 at 11:45 AM with Nurse Aide (NA) #1 revealed they have a shower schedule book and each resident received two showers per week. She stated Resident #35's shower days were Wednesday and Saturday and she did not recall him ever refusing his showers. She stated she was not aware Resident #35 wanted three showers per week. NA #1 stated they have shower book that tells them what days resident showers were due. She stated they have care guides for each resident but Resident #35's care guide did not indicate he wanted 3 showers per week.

An interview conducted on 09/07/17 at 2:46 PM with the Social Worker (SW) revealed when a resident was admitted to the facility she informed them or their responsible party they would receive two showers per week. She stated a resident could have more than two showers per week but they had to ask for them. She stated she wasn't aware of any facility staff asking the residents for their shower preferences.

On 09/08/17 at 2:35 PM the Director of Nursing stated that she was aware that residents were not getting their showers consistently. She stated the facility was having some staffing issues. She further stated that if a resident refused a shower, the nurse aide was to get the nurse to assist. She stated she reconfigured the sheets to ensure each staff knew the schedule and if there was no documentation on the shower sheet, the shower was probably not given. In addition, it was her understanding that the Social Worker would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 11	F 242		

obtain a resident's choice in the number of showered they wanted while at the facility. She did not expect nursing to obtain that information. She further stated if a resident wanted more than 2 showers a week and was care planned for more than 2 showers per week it should be documented on the NAs care guide.

6. Resident #79 was admitted to the facility on 07/03/17 with diagnoses of anemia, non-Alzheimer's dementia and diabetes.

Review of the admission Minimum Data Set (MDS) dated 07/11/17 revealed Resident #79 was cognitively intact and required supervision for eating.

Review of Resident #79's tray card revealed his dislikes were spicy foods, sausage, green beans and beans.

Observations made on 09/06/17 at 12:55 PM of Resident #79's lunch tray revealed him to have mashed potatoes with brown gravy, mixed vegetables (green beans and carrots), meatloaf, biscuit and pudding.

An interview conducted with Resident #79 on 09/06/17 at 12:55 PM revealed he was very unhappy with his tray and stated he had told the staff over and over that he didn't eat gravy or beans of any kind. He stated he was tired of receiving foods he told them he wouldn't eat.

An interview conducted on 09/06/17 at 4:43 PM with the Registered Dietician (RD) revealed it was her responsibility to meet with each resident or their responsible party to discuss their likes and dislikes. She stated she completed a likes and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 12 dislikes form and sent it to the kitchen to be placed on the tray card. She stated she must have missed putting gravy as a dislike for Resident #79. She further stated Resident #79 should not have received green beans on his plate on 09/06/17 due to having a dislike for them on his tray card. An interview conducted on 09/07/17 at 11:55 AM with the facility Dietary Consultant revealed Resident #79 should not have received green beans on his tray on 09/06/17. She stated the dislike was overlooked by the dietary staff when they plated the tray. An interview conducted with the Director of Nursing on 09/07/17 at 2:40 PM revealed it was her expectation for residents dislikes to be honored and not sent on their trays.	F 242		
F 252 SS=E	483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. §483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 252		10/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

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F 252	Continued From page 13 (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. This REQUIREMENT is not met as evidenced by: Based on observations and resident and staff interviews the facility failed to serve resident meals in a non-institutional manner for 9 of 9 residents (Residents #71, #66, #7, #6, #59, #30, #35, #53 and #39) who ate in the dining rooms. The findings included: Resident #59 was admitted to the facility on 10/13/16 with diagnoses of high blood pressure, peripheral vascular disease and diabetes. Review of the quarterly Minimum Data Set dated 10/13/17 revealed Resident #59 was cognitively intact and able to voice concerns. Observations made on 09/05/17 at 12:45 PM, 09/06/17 at 8:45 AM, 09/06/17 at 12:55 PM and 09/07/17 at 11:46 AM revealed all residents that ate in the dining rooms received their meals on pink and cream colored institutional style trays. The plates and other food items were not removed from the trays during the meals. An interview conducted on 09/07/17 at 11:50 AM with the facility Dietary Consultant revealed the pink trays that resident meals were served on did not provide any kind of insulation to keep food	F 252	F 252 The position of Magnolia Lane Nursing and Rehabilitation Center regarding the process that led to this deficiency was the nursing staff had a knowledge deficit regarding residents receiving meals in a homelike environment. On 9/11/17, residents #59, 71, 66, 7, 30, 35, 53, 39 and 6 had their meals served in a non-institutional manner by removing the plates and other food items from the pink/cream colored trays during breakfast, lunch and dinner. Using an audit tool, on 9/25/17, the Director of Nursing and Administrator completed a 100% audit of residents during lunch to ensure that all resident were served in a homelike, non-institutional environment by removing the plates and other food items from the pink/cream colored trays. On 9/11/17, the Director of Nursing and Staff Facilitator began an in-service for all nursing staff to remove the plates and	

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	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 252	Continued From page 14 warm. She stated she had requested to order domes to cover the plates for a homelike environment feel but was told she could not order them. An interview conducted on 09/08/17 at 9:32 AM with Resident #59 revealed she did not like being served on the pink tray because they looked old and stained. She further stated eating off the tray made her feel like she was back in elementary school. An interview conducted on 09/08/17 at 4:15 PM with the Director of Nursing revealed it was her expectation for resident meals to be served in a homelike environment.	F 252	other food items from the pink/cream colored institutional style trays to provide a more homelike environment for our residents. This in-service was completed on 10/2/17. Using an audit tool, a designated department manager will observe each meal daily in the dining rooms to ensure that plates and other food items are removed from the pink/cream institutional style trays 5 x per week x 4 weeks. The department managers will continue to observe the dining rooms Monday-Friday during lunch indefinitely to ensure staff continue to provide a homelike environment for our residents. The audit tools will be reviewed at the monthly Executive QI Committee meeting to ensure the facility maintains implemented procedures and monitors these interventions for continued compliance.	
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain a clean and sanitary environment by keeping personal items labeled, covered and off the floor, keeping floors free of stains and in good repair, keeping caulking around toilets clean and intact, keeping the	F 253	F 253 The position of Magnolia Lane Nursing and Rehabilitation Center regarding the process that led to this deficiency was the staff failed to follow established facility	10/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

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F 253	Continued From page 15 shower room with clean grout and tiles secured to the floor, and keeping walls and door frames painted and free of scaring. This affected rooms accessible to 36 of 54 residents in the facility in 21 resident rooms (Room #82, #83, #84, #85, #86, #87, #88, #89, #90, #94, #95, #98, #99, #102, #103, #104, #105, #108, #109, #112, and #113). The findings included: 1. The one communal shower room currently in use was inspected during initial tour on 09/05/17 starting at 8:30 AM and was observed to have missing tiles at the drain and loose tiles around the drain. Upon follow up observations on 09/06/17 at 11:26 AM and on 09/08/17 at 3:24 PM revealed there were missing and loose tiles around the drain approximately 3 inches by 8 inches with loose gravel where the tiles were missing and standing water in this area. In addition, the grout in between the tiles around the bottom sides of the shower was darkened in spots which could be removed with a paper towel. Interview with the Maintenance Director on 09/08/17 at 3:24 PM revealed he was unaware of the loose and missing tiles in the shower room. Interview with the Housekeeping Supervisor on 09/08/17 at 3:24 PM revealed she expected the grout between the shower tiles to have been cleaned. 2. Bathrooms in the following rooms were observed to have stained floors, and/or darkened or missing caulking around the base of the	F 253	policy and procedure in relation to Housekeeping and Maintenance Services. 1. Communal Shower Room: On 9/9/17, the loose tiles in the communal shower room stall around the drain were removed. New tiles were placed around the drain by the Maintenance Director. The darkened spots in between the tiles around the bottom sides of the shower were removed using a disinfectant on 9/8/17 by the Housekeeping Supervisor. 2. Bathrooms: During the week of 9/11/17-9/15/17, the stained tiles in the bathrooms of rooms 82/83, 84/85, 87, 88/89, 94/95 and 103 were removed and replaced with new tiles by the Maintenance Director. The bases of the commodes in rooms 86, 87, 94/95 and 102 were re-caulked by the Maintenance Director. Door frames of the bathroom doors of rooms 87 and 98/99 were painted to include the bathroom doors of rooms 102 and 104/105 by the floor tech. From 9/20/17-9/23/17, the baseboard heaters in the bathrooms 103 and 104/105 were repaired and painted. by the Maintenance Director. On 9/14/17, the tile under the sink of room 86 was replaced by the Maintenance Director. Stained tiles under the window in room 103 were stripped/waxed by the floor tech on 9/29/17. The bathroom of room #90 was repainted with new flooring placed and the commode was re-caulked around the base by the Maintenance Director, completed on 9/20/17.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

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F 253	Continued From page 16 commodes, and or scraped metal door frames, and or rusty pulled away metal heater covers as follows: a. Bathroom shared by 4 residents in Rooms 88 and 89 revealed orange stains on the floor around the commode and black matter between the separating tiles on the floor as noted on 09/05/17 at 10:30 AM, 09/06/07 at 8:32 AM, 09/07/17 at 4:51 PM and 09/08/17 at 3:19 PM. b. Bathroom in the private room 87 revealed stained flooring around the commode, dark build up in the cracks of the floor tiles and the caulking around the commode was discolored and cracked on 09/06/17 at 8:22 AM. This remained the same on 09/06/17 at 11:24 AM and on 09/07/17 at 4:54 PM during which times the metal door frames were observed to have been scraped down to the metal. c. Bathroom shared by 4 residents in rooms 94 and 95 revealed the floor around the commode was stained, a tile was cracked in front of commode and the caulking at the base of the toilet was stained and cracked on 09/05/17 at 10:09 AM. This remained on 09/06/17 at 9:00 AM on 09/07/17 at 4:56 PM and on 09/08/17 at 3:25 PM. d. Bathroom in room 86 shared by 2 residents was observed on 09/05/17 at 11:07 AM with a black stain on the floor under the sink surrounded by a gray discoloration. A tile approximately 24 inches by 1/2 inch was missing under sink next to the baseboard, and there was no caulking around the base of the commode revealing a rust colored stain around the commode. This remained the same when observed on 09/06/17 at 9:03 AM,	F 253	3. Personal Care Equipment: A. On 9/8/17, the unlabeled urinal and plastic bag with the unlabeled cup were removed from the bathroom of rooms 88/89 by the Director of Nursing. A new labeled urinal was provided for the resident. B. On 9/9/17, the personal fan of the resident in room #95 was cleaned by the Housekeeping staff. C. On 9/8/17, the Housekeeping staff disinfected the bedside commode in room #86. D. On 9/8/17, the toilet plunger in the bathroom of rooms 84/85 was covered and the unlabeled wash basin was discarded by the housekeeping staff. E. On 9/8/17, the urine hat was discarded from the bathroom of room 102 by the Director of Nursing. F. On 9/9/17, the unlabeled, uncovered bed pan was discarded from the bathroom of rooms 104/105 by the Director of Nursing. A new labeled, covered bed pan was provided for the resident. G. On 9/9/17, the unlabeled, uncovered wash basin on the floor was discarded from the bathroom of rooms 108/109 by the Director of Nursing. A new labeled, covered wash basin was provided for each resident in rooms 108/109. H. On 9/9/17, the unlabeled, uncovered wash basin and unlabeled urinal on the handrail was discarded from the bathroom of rooms 112/113 by the Director of Nursing. Labeled, covered wash basins and urinals were provided. 4. Walls: A. On 9/19/17, the wood behind the bed in room #88 was removed and the wall repaired and painted by the Maintenance Director. B. On 9/20/17, the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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MAGNOLIA LANE NURSING AND REHABILITATION CENTER	107 MAGNOLIA DRIVE MORGANTON, NC 28655

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F 253	Continued From page 17 09/06/17 at 12:43 PM, on 09/07/17 at 4:58 PM and on 09/08/17 at 3:27 PM. e. Bathroom shared by room 84 and 85 by 4 residents was observed on 09/05/17 at 11:27 AM with stained flooring behind the commode, and all tiles having black grime between the tile spaces. This remained the same during observations on 09/06/17 at 9:08 AM, on 09/07/17 at 5:00 PM and on 09/08/17 at 3:29 PM. f. Bathroom shared by 2 residents in rooms 82 and 83 was observed to have a stained floor around the commode on 09/05/17 at 10:37 AM, on 09/05/17 at 4:30 PM, on 09/06/17 at 8:10 AM, on 09/07/17 at 5:03 PM and on 09/08/17 at 3:32 PM. g. Bathroom shared by 2 residents in rooms 98 and 99 was observed with stained floor tile and scraped metal door frames on 09/07/17 at 5:06 PM and on 09/08/17 at 3:34 PM. h. Bathroom in room 102 shared by 2 residents was observed with missing caulking around the base of the commode and scraped bathroom door on 09/05/17 at 12:11 PM, on 09/06/17 at 8:49 AM, on 09/07/17 at 5:08 PM and 09/08/17 at 3:36 PM. i. Bathroom in room 103 shared by 2 residents revealed a dark stain on the floor under the window and the metal cover was pulled away from the baseboard heater in the bathroom during observations on 09/05/17 at 10:33 PM. This remained the same as well as the toilet tank cover did not fit the commode during observations made on 09/06/17 at 11:42 AM, on 09/07/17 at 5:10 PM and on 09/08/17 at 3:37 PM.	F 253	wood behind the bed in room #82 was removed and the wall repaired and painted by the Maintenance Director. C. On 9/14/17, the bathroom walls of rooms 98/99 were painted by the floor tech. D. On 9/25/17, the wall above the bed in room #99 was repaired. Both the wall and the light fixture were painted by the Maintenance Director. E. On 9/26/17, the walls in room #108 were repaired and the room painted by the Maintenance Director. Using an audit tool, on 9/29/17, the Administrator completed a 100% audit of resident rooms on Main and Central Halls to ensure paint, walls, tiles and the environment were sanitary, orderly and comfortable for our residents. This audit included resident personal belongings to ensure they were all labeled and covered according to facility policy. Any items identified as unlabeled were discarded with new personal items provided, labeled and covered. 100% of staff will be in-serviced by 10/2/17 by the Director of Nursing regarding the importance of completing work orders to ensure the Maintenance Director is aware of needed repairs and painting to provide a more homelike environment for our residents. This in-service will include the need to label and cover personal care items belonging to the residents. Using an audit tool, the Department Managers will make rounds of assigned	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

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F 253	Continued From page 18 j. Bathroom shared by rooms 104 and 105 and by 4 residents was observed to have the bathroom doors heavily scratched of paint, rusty metal baseboard heater cover with an edge protruding several inches out from heater during observations made on 09/05/17 at 10:23 AM, on 09/06/17 at 8:34 AM, on 09/07/17 at 12:34 PM and on 09/08/17 at 3:39 PM. On 09/08/17 at 3:39 PM, the Maintenance Director stated he was unaware of the condition of the baseboard heater. k. The bathroom in room 90 shared by 2 residents was observed with paint spots over most of the floor and on the vinyl baseboards on 09/06/17 at 11:15 AM, on 09/07/17 at 4:49 PM and on 09/08/17 at 3:16 PM. During these times the floor was observed stained and the caulking around the base of the commode had black spots in various places. The Maintenance Director stated during interview on 09/08/17 at 3:05 PM that he completed weekly rounds to check rooms and reviews and takes care of work orders as they come in daily. The Maintenance Director further explained, when he completed weekly rounds he walked and looked into the rooms and if something caught his eye that needed attention he would address it. He stated that the facility was currently working on lightening up bathrooms with new paint and replacing the floor as needed. In addition, if the bedroom adjacent to the bathrooms needed attention, he would address that. He stated that a floor technician was helping paint the bathrooms and he guessed that 3 bathrooms were being painted each week.	F 253	rooms each day worked to report any needed repairs or painting to the Maintenance Director. Any unlabeled/ uncovered personal care items will be discarded and reported to the Director of Nursing and Staff Facilitator for replacement of personal care items and re-education of staff. The Housekeeping Supervisor will be made aware of any resident personal items that need to be cleaned. These rounds will continue indefinitely. The audit tools will be reviewed monthly at the Executive QI Committee meeting to ensure the facility maintains implemented procedures and monitors these interventions for continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 19 The Administrator shared a plan of renovations on 09/08/17 at 3:45 PM she developed on 07/06/17 which identified in general but not specific rooms that bathroom walls needed repair and paint, toilets needed to be recaulked at their base, and floors were dirty behind and around toilets. The goal date to achieve this was 09/15/17. An undated bathroom audit revealed 10 bathrooms in need of repair including room 90 was to be painted and the toilet pulled up; the bathroom in room 87 needed caulking around the toilet; the floor was cracked in room 94/95; caulking around the commode was needed in room 86; and the floor needed to be cleaned behind the toilet in room 84/85. The Administrator stated that the plan was delayed due to problems in the kitchen and having to move residents to the central unit before they were ready. She stated she did not realize the extent of environmental problems. She further stated that she and her department heads do environmental rounds and she directed the maintenance department which rooms to fix next. She stated there was no set plan or priority set. 3. Personal care equipment was stored soiled and or without being labeled as follows: a. Bathroom shared by 4 residents in Rooms 88 and 89 revealed on 09/06/17 at 11:17 AM a wet urinal unlabeled and uncovered above the commode, a wet plastic cup with brownish matter in a bag unlabeled on the handrail. On 09/07/17 at 4:51 PM the urinal was gone but the soiled plastic bagged unlabeled cup was still on the bathroom hand rail. On 09/08/17 at 3:19 PM there was an unlabeled urinal on the shelf above the commode.	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

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F 253	Continued From page 20	F 253		

b. Bedroom 95 was observed with a personal floor fan with a coating of gray dust covering the majority of the blades and front grill of the fan 09/05/17 at 10:54 am and 09/06/17 at 8:58 AM. This soiled fan was blowing on a resident with clumps of the gray dust build up clinging to the front grill of the fan when observed on 09/07/17 4:46 PM and on 09/08/17 at 3:25 PM.

On 09/08/17 at 3:25 PM, the Housekeeping Supervisor who also observed the soiled fan stated the housekeepers were responsible for the cleanliness of the fan.

c. Bathroom in room 86 shared by 2 residents had a bedside commode which was observed with dried soiled matter inside on 09/05/17 at 11:07 AM, on 09/06/17 at 9:03 AM, 09/06/17 at 12:43 PM, on 09/07/17 at 4:58 PM and on 09/08/17 at 3:27 PM.

On 09/08/17 at 3:27 PM the Housekeeping Supervisor stated that the bedside commode should be cleaned by the housekeepers.

d. In the bathroom shared by rooms 84 and 85 (shared by 4 residents was an uncovered toilet plunger located in an unlabeled wash basin on the floor when observed on 09/05/17 at 11:29/17, on 09/06/17 at 11:36 AM, on 09/07/17 at 5:00 PM and on 09/08/17 at 3:29 PM.

e. Bathroom in room 102 shared by 2 residents had an unlabeled, uncovered urine hat on the floor on 09/05/17 at 12:11 PM and on 09/06/17 at 8:50 AM. On 09/07/17 at 5:08 PM and on 09/08/17 at 3:36 PM the unlabeled, uncovered urine hat was located on the back of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

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F 253	Continued From page 21	F 253		

commode.

f. Bathroom shared with rooms 104 and 105 with 4 residents had an unlabeled, uncovered bedpan above the commode on 09/05/17 at 10:23 AM, on 09/06/17 at 8:34 AM, on 09/07/17 at 12:34 PM and on 09/08/17 at 3:39 PM.

g. In the bathroom shared by rooms 108 and 109 used by 3 residents revealed an unlabeled, uncovered wash basin on the floor beside the commode on 09/05/17 at 11:36 AM, on 09/07/17 at 5:14 PM and on 09/08/17 at 3:41 PM.

h. In the bathroom shared by rooms 112 and 113 and shared by 4 residents was an uncovered, unlabeled soiled with a large amount of white residue wash basin on the shelf and a soiled unlabeled urinal on the handrail beside the commode on 09/05/17 at 11:05 AM, on 09/06/17 at 8:30 AM, on 09/07/17 at 5:17 PM and on 09/08/17 at 3:42 PM.

A housekeeper was interviewed on 09/07/17 at 11:52 AM and she stated she was not responsible for the personal care equipment in resident rooms or bathrooms.

Interview with the Housekeeping Supervisor on 09/08/17 at 3:09 PM revealed that if personal care equipment needed cleaning she expected her housekeepers to clean them.

The Administrator stated during interview on 09/08/17 at 3:10 PM that last year they put up shelves in the bathrooms to keep personal care items off the floors. She stated her care giving aides were responsible for labeling and dating the personal care items and replacing them monthly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 22	F 253		

She expected bed pans and the like to be bagged. In addition department managers were to make rounds.

4. Walls:

a. Room 88 by the beds had the wood behind the bed with deep gouges and paint scraped off on 09/05/17 at 10:30 AM, 09/06/17 at 8:32 AM, on 09/07/17 at 4:51 PM and on 09/08/17 at 3:19 PM.

b. Room 82 bed B had large gouged areas with missing paint in the wood located behind the bed on 09/07/17 at 5:03 PM and on 09/08/17 at 3:32 PM.

c. Bathroom shared by 2 residents residing in rooms 98 and 99 revealed the walls around the bathroom were scraped and exposed wall board when observed on 09/05/17 3:28 PM, on 09/06/17 at 8:51 PM, on 09/07/17 at 5:06 PM and on 09/08/17 at 3:34 PM.

d. The wall above the bed in Room 99 was observed to have multiple holes above the light fixture and the light fixture itself was scraped up in multiple placed during observations made on 09/05/17 at 3:28 PM, on 09/07/17 at 5:06 PM and on 09/08/17 at 3:34 PM.

e. The walls by both beds in room 108 were scraped exposing the paint color the room used to be when observed on 09/07/17 at 5:14 PM and on 09/08/17 at 3:41 PM. In addition at these times the wall above the television was observed patched with the different colored paint where a mounting device had been removed.

The Administrator shared a plan of renovations

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 23 on 09/08/17 at 3:45 PM she developed on 07/06/17 which identified in general-not specific rooms that bathroom walls needed repair and paint, toilets needed to be recaulked at their base, and floors were dirty behind and around toilets. The goal date to achieve this was 09/15/17. The Administrator stated as the bathrooms were being addressed, if the bedroom needed attention that would be taken care of including paint and removing the gouged wood around the beds and replacing them with vinyl sheets. She stated she did not realize the extent of environmental problems. She further stated that she and her department heads do environmental rounds and she directed the maintenance department which rooms to fix next. She stated there was no set plan or priority set.	F 253		
F 273 SS=E	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT (b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 273	F 273	10/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 273	Continued From page 24 facility failed to complete Care Area Assessments within the 14 day time frame when conducting comprehensive assessments. This affected 9 of 30 sampled residents who were reviewed for comprehensive assessments (Residents #5, #6, #7, #15, #23, #32, #41, #44, and #66). The findings included: 1. Resident #32 was admitted most recent to the facility on 03/25/15 with diagnoses including diabetes, edema, congestive heart failure and chronic obstructive pulmonary disease. His annual Minimum Data Set dated 04/25/17 coded him with intact cognition, requiring no assistance to limited assistance for most activities of daily living skills (ADL) and being occasionally incontinent of bladder but always continent of bowel. His Care Area Assessment (CAA) for ADL was completed on 05/23/17. His incontinence CAA was completed on 05/22/17. Interview with the MDS nurse on 09/08/17 at 11:15 AM revealed she took over completing the MDS Assessments in June 2017. She was unable to explain how or why the CAAs were so delayed for this resident. She stated that the MDS and CAAs were behind when she came to work at the facility and she had been working hard to get the all caught up. She stated her goal was to complete the CAAs within 3 days following the Assessment Reference Date of the MDS. An interview conducted on 09/08/17 at 2:30 PM with the Director of Nursing (DON) revealed she did not know a lot about MDS and knew the	F 273	The position of Magnolia Lane Nursing and Rehabilitation Center regarding the process that led to this deficiency was the staff failed to follow established facility policy and procedure. 1. On 5/23/17, the comprehensive Minimum Data Set (MDS) for resident #32 with an Assessment Reference Date (ARD) of 4/25/17, was completed by the MDS Coordinator. 2. The Care Area Assessment (CAA) for cognition and Activities of Daily Living for resident #41 with an ARD of 1/21/17 was completed on 3/20/17. 3. The CAA for Activities of Daily Living for resident #44 with an ARD of 5/12/17 was completed on 6/13/17 by the MDS Coordinator. 4. The CAA for Activities of Daily Living for resident #23 with an ARD of 4/4/17 was completed on 5/22/17 by the MDS Coordinator. 5. For resident #7, the MDS with an ARD 1/5/17, the Activities of Daily Living CAA was completed on 2/14/17, Mood CAA was completed on 1/31/17 and the Psychotropic Drug Use CAA was completed on 2/14/17 by the MDS Coordinator. 6. For resident #66 with a MDS ARD of 4/21/17, the Nutrition CAA was completed on 5/24/17 by the MDS Coordinator. 7. For resident #5 with a MDS ARD of 5/12/17, the Falls CAA was completed on 5/30/17 by the MDS Coordinator. 8. For resident #6 with a MDS ARD 2/14/17, the Restraint CAA was completed by the MDS Coordinator on 4/12/17. 9. For resident #15 with a MDS ARD 1/3/17, the Falls CAA was completed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 273	Continued From page 25 Administrator had spoken to the previous MDS Nurse a few times about MDS issues. The DON stated it was her expectation for the MDS and CAAs to be completed as required. An interview conducted on 09/08/17 at 5:07 PM with the Administrator revealed she had issues with the previous MDS Nurse and had counseled her and offered to send her for more training but then she quit. She stated she had recently hired a new MDS Nurse and hoped that would improve MDS time requirements. She stated she had been aware of the timing issues with the CAAs. 2. Resident #41 was admitted to the facility most recently on 09/02/13. Her diagnoses included hemiplegia, cognitive, social and emotional deficit, contractures,dysphagia, and chronic pain. The Minimum Data Set (MDS), an annual dated 01/21/17 coded her with moderate impaired cognition, having some mood indicators, having behaviors, requiring extensive to total assistance wit most activities of daily living skills (ADL), and having range of motion impairments. The Care Area Assessments for the triggered areas of cognition and ADL were not completed until 03/20/17. Interview with the MDS nurse on 09/08/17 at 11:15 AM revealed she took over completing the MDS Assessments in June 2017. She was unable to explain how or why the CAAs were so delayed for this resident. She stated that the MDS and CAAs were behind when she came to work at the facility and she had been working hard to get the al caught up. She stated her goal was to complete the CAAs within 3 days following	F 273	on 1/30/17 by the MDS Coordinator. On 10/2/17, an audit will be completed by the MDS nurse using the MDS progress list and MDS scheduler to identify any late comprehensive or admission assessments. Any identified late comprehensive or admission assessments will be completed by 10/3/17 by the MDS nurse. The MDS nurse, Dietary Manager, Activity Director and Social Worker were in-serviced on the timely completion of the comprehensive and admission assessments per the RAI Manual by the Administrator on 9/25/17. Using an audit tool, on 10/2/17, the Director of Nursing will begin monitoring the MDS comprehensive and admission assessments to ensure that all sections of the MDS to include the CAA's are completed timely pre the RAI Manual. These audits will review 100% of comprehensive and admission assessments x 4 weeks then 50% of comprehensive and admission assessments x 4 weeks. The audits will be reviewed at the monthly Executive QI Committee meetings to ensure the facility maintains implemented procedures and monitors these interventions for continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

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F 273	Continued From page 26	F 273		

the Assessment Reference Date of the MDS.

An interview conducted on 09/08/17 at 2:30 PM with the Director of Nursing (DON) revealed she did not know a lot about MDS and knew the Administrator had spoken to the previous MDS Nurse a few times about MDS issues. The DON stated it was her expectation for the MDS and CAAs to be completed as required.

An interview conducted on 09/08/17 at 5:07 PM with the Administrator revealed she had issues with the previous MDS Nurse and had counseled her and offered to send her for more training but then she quit. She stated she had recently hired a new MDS Nurse and hoped that would improve MDS time requirements. She stated she had been aware of the timing issues with the CAAs.

3. Resident #44 was admitted to the facility on 05/02/17 with diagnoses including cerebral infarction, anxiety disorder, borderline personality disorder, hemiplegia and peripheral vascular disease.

The admission Minimum Data Set dated 05/12/17 coded her with intact cognition, requiring extensive assistance with most activities of daily living skills, always being incontinent and receiving therapy services.

The Care Area Assessment for Activities of Daily Living skills was not completed until 06/13/17.

Interview with the MDS nurse on 09/08/17 at 11:15 AM revealed she took over completing the MDS Assessments in June 2017. She was unable to explain how or why the CAAs were so delayed for this resident. She stated that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 273	Continued From page 27	F 273		

MDS and CAAs were behind when she came to work at the facility and she had been working hard to get the al caught up. She stated her goal was to complete the CAAs within 3 days following the Assessment Reference Date of the MDS.

An interview conducted on 09/08/17 at 2:30 PM with the Director of Nursing (DON) revealed she did not know a lot about MDS and knew the Administrator had spoken to the previous MDS Nurse a few times about MDS issues. The DON stated it was her expectation for the MDS and CAAs to be completed as required.

An interview conducted on 09/08/17 at 5:07 PM with the Administrator revealed she had issues with the previous MDS Nurse and had counseled her and offered to send her for more training but then she quit. She stated she had recently hired a new MDS Nurse and hoped that would improve MDS time requirements. She stated she had been aware of the timing issues with the CAAs.

4. Resident #23 was admitted to the facility on 01/08/15 and had diagnoses including hypertension, diabetes, depression, respiratory failure and had a tracheostomy.

His annual Minimum Data Set dated 04/04/17 coded him with intact cognition, requiring limited assistance with transfers, walking and dressing and hygiene, requiring extensive assistance with bed mobility, toileting and bathing.

The Care Area Assessment for Activities of Daily Living skills was dated 05/22/17.

Interview with the MDS nurse on 09/08/17 at 11:15 AM revealed she took over completing the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 273	Continued From page 28	F 273		

MDS Assessments in June 2017. She was unable to explain how or why the CAAs were so delayed for this resident. She stated that the MDS and CAAs were behind when she came to work at the facility and she had been working hard to get the al caught up. She stated her goal was to complete the CAAs within 3 days following the Assessment Reference Date of the MDS.

An interview conducted on 09/08/17 at 2:30 PM with the Director of Nursing (DON) revealed she did not know a lot about MDS and knew the Administrator had spoken to the previous MDS Nurse a few times about MDS issues. The DON stated it was her expectation for the MDS and CAAs to be completed as required.

An interview conducted on 09/08/17 at 5:07 PM with the Administrator revealed she had issues with the previous MDS Nurse and had counseled her and offered to send her for more training but then she quit. She stated she had recently hired a new MDS Nurse and hoped that would improve MDS time requirements. She stated she had been aware of the timing issues with the CAAs.

5. Review of the medical record revealed Resident #7 was admitted on 11/30/11 with diagnoses including dementia and Alzheimer's disease.

Review of the annual Minimum Data Set (MDS) for Resident #7 revealed the assessment reference date (ARD) was 01/05/17.

Review of Resident #7's Care Area Assessment (CAA) Summary for Activities of Daily Living revealed it was dated as complete on 02/14/17.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 273	Continued From page 29	F 273		

Review of Resident #7's CAA Summary for Mood State revealed it was dated as complete on 01/31/17.

Review of Resident #7's CAA Summary for Psychotropic Drug Use revealed it was dated as complete on 02/14/17.

An interview was conducted on 09/08/17 at 11:15 AM with the MDS Nurse. She stated she took over MDS Assessments in June 2017 and had not completed Resident #7's annual MDS in January 2017. She stated the MDS and CAAs were behind when she came to the facility and she had been working hard to get caught up. She stated her goal was to complete the CAAs within 3 days following the assessment reference date of the MDS.

An interview conducted on 09/08/17 at 2:30 PM with the Director of Nursing (DON) revealed she did not know a lot about MDS and knew the Administrator had spoken to the previous MDS Nurse a few times about MDS issues. The DON stated it was her expectation for the MDS assessments and CAAs to be completed as required.

An interview conducted on 09/08/17 at 5:07 PM with the Administrator revealed she had issues with the previous MDS Nurse and had counseled her and offered to send her for more training but then she quit. She stated she had recently hired a new MDS Nurse and hoped that would improve MDS time requirements. She stated she had been aware of the timing issues with the CAAs.

6. Resident #66 was admitted to the facility on 04/19/16 with diagnoses of heart failure, aphasia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 273	Continued From page 30	F 273		

and cerebral vascular accident.

Review of the annual Minimum Data Set (MDS) for Resident #66 had an assessment reference date of 04/21/17.

Review of the Care Area Assessments (CAAs) for nutrition which was a triggered area was dated as complete on 05/24/17.

An interview was conducted on 09/08/17 at 11:15 AM with the MDS Nurse. She stated she took over MDS in June 2017. She was unable to explain how or why the CAA was so delayed for this resident. She stated the MDS and CAAs were behind when she came to the facility and she had been working hard to get caught up. She stated her goal was to complete the CAAs within 3 days following the assessment reference date of the MDS.

An interview conducted on 09/08/17 at 2:30 PM with the Director of Nursing (DON) revealed she did not know a lot about MDS and knew the Administrator had spoken to the previous MDS Nurse a few times about MDS issues. The DON stated it was her expectation for the MDS and CAAs to be completed as required.

An interview conducted on 09/08/17 at 5:07 PM with the Administrator revealed she had issues with the previous MDS Nurse and had counseled her and offered to send her for more training but then she quit. She stated she had recently hired a new MDS Nurse and hoped that would improve MDS time requirements. She stated she had been aware of the timing issues with the CAAs.

7. Review of Resident #5's medical record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 273	Continued From page 31	F 273		

revealed she was admitted to the facility on 05/17/16 with diagnoses including dementia, osteoporosis, peripheral vascular disease and depression.

Review of Resident #5's annual Minimum Data Set (MDS) dated 05/12/17 revealed her cognition was moderately impaired and she required supervision to limited assistance with most of her activities of daily living.

Resident #5's Care Area Assessment (CAA) for falls was completed 05/30/17.

During an interview with the MDS Nurse on 09/08/17 at 11:15 AM she stated she took over the MDS position in June 2017. The MDS Nurse was unable to explain why or how the CAAs for Resident #5 was so far behind. The MDS Nurse stated that the MDS assessments and CAAs were behind when she came to work at the facility and she had been working hard to get them caught up. She further stated it was her goal to complete the CAAs within 3 days following the Assessment Reference Date of the MDS.

An interview with the Director of Nursing (DON) on 09/08/17 at 2:30 PM revealed she did not know much about the MDS process but knew the Administrator had spoken to the previous MDS Nurse a few times about some MDS issues. The DON stated she expected the MDSs and CAAs to be completed within the required time frame.

An interview was conducted with the Administrator on 09/08/17 at 5:07 PM who revealed she had issues with the previous MDS Nurse and had counseled her and offered to send her for more training but she quit. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 273	Continued From page 32	F 273		

Administrator stated she recently hired a new MDS Nurse and hoped the MDS timing would improve. She further stated she had been aware of the timing issues with the CAAs.

8. Review of Resident #6's medical record revealed she was admitted to the facility on 04/25/13 with diagnoses including Alzheimer's disease, renal insufficiency, hypertension and diabetes mellitus.

Resident #6's annual Minimum Data Set (MDS) dated 02/14/17 revealed she had severely impaired cognition, required extensive assistance with most of her activities of daily living and used a trunk restraint daily.

Review of Residents #6's Restraint Care Area Assessment (CAA) revealed the CAA was dated 04/12/17.

During an interview with the MDS Nurse on 09/08/17 at 11:15 AM she stated she took over the MDS position in June 2017. The MDS Nurse was unable to explain why or how the CAAs for Resident #6 was so far behind. The MDS Nurse stated that the MDS assessments and CAAs were behind when she came to work at the facility and she had been working hard to get them caught up. She further stated it was her goal to complete the CAAs within 3 days following the Assessment Reference Date of the MDS.

An interview with the Director of Nursing (DON) on 09/08/17 at 2:30 PM revealed she did not know much about the MDS process but knew the Administrator had spoken to the previous MDS Nurse a few times about some MDS issues. The DON stated she expected the MDSs and CAAs to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 273	Continued From page 33	F 273		

be completed within the required time frame.

An interview was conducted with the Administrator on 09/08/17 at 5:07 PM who revealed she had issues with the previous MDS Nurse and had counseled her and offered to send her for more training but she quit. The Administrator stated she recently hired a new MDS Nurse and hoped the MDS timing would improve. She further stated she had been aware of the timing issues with the CAAs.

9. Review of Resident #15's medical record revealed she was admitted to the facility on 12/30/15 with diagnoses that included Alzheimer's disease, Parkinson disease, arthritis and depression.

Resident #15's annual Minimum Data Set (MDS) dated 01/03/17 revealed she had severely impaired cognition and required extensive to total dependence for the majority of her activities of daily living.

Review of Resident #15's Care Area Assessment (CAA) for falls revealed the CAA was dated 01/30/17.

During an interview with the MDS Nurse on 09/08/17 at 11:15 AM she stated she took over the MDS position in June 2017. The MDS Nurse was unable to explain why or how the CAAs for Resident #15 was so far behind. The MDS Nurse stated that the MDS assessments and CAAs were behind when she came to work at the facility and she had been working hard to get them caught up. She further stated it was her goal to complete the CAAs within 3 days following the Assessment Reference Date of the MDS.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 273	Continued From page 34 An interview with the Director of Nursing (DON) on 09/08/17 at 2:30 PM revealed she did not know much about the MDS process but knew the Administrator had spoken to the previous MDS Nurse a few times about some MDS issues. The DON stated she expected the MDSs and CAAs to be completed within the required time frame. An interview was conducted with the Administrator on 09/08/17 at 5:07 PM who revealed she had issues with the previous MDS Nurse and had counseled her and offered to send her for more training but she quit. The Administrator stated she recently hired a new MDS Nurse and hoped the MDS timing would improve. She further stated she had been aware of the timing issues with the CAAs.	F 273		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278		10/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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F 278	Continued From page 35 (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately assess 2 of 30 sampled residents for toileting abilities. Residents #41 and #44's toileting abilities were coded as not having occurred during their assessments. The findings included: 1. Resident #41 was admitted to the facility most recently on 07/03/12 with diagnoses including hemiplegia, cognitive and social deficits, contractures, dysphagia and chronic pain. Her annual Minimum Data Set (MDS) dated 01/21/17 coded her as requiring total assistance of two staff for toileting. The quarterly MDS dated 04/21/17 coded her as toileting activity did not occur.	F 278	F 278 The position of Magnolia Lane Nursing and Rehabilitation Center regarding the process that led to this deficiency was the MDS Coordinator failed to follow established facility policy and procedure related to the accurate coding of the MDS. On 9/25/17, Minimum Data Set (MDS)for resident #41 with an Assessment Reference Date (ARD) of 4/21/17, was modified by the MDS nurse to provide a more accurate assessment of the resident's toileting needs. The assessment dated 4/21/17 indicated toileting had not occurred. The coding was modified to indicate resident #41 required total assistance from two caregivers.	

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F 278	Continued From page 36 Interview with the MDS nurse on 09/08/17 at 11:15 AM revealed she began completing MDS assessments in June 2017. She stated she could not account for the inaccurate coding of toileting for Resident #41, however, she has been training the nurse aides on the correct coding of activities of daily living skills. Interview with the Administrator on 09/08/17 at 5:07 PM revealed that she was not surprised that errors were found with the MDS coding. She revealed that she had trained a MDS staff person and wanted to provide more education, however, she quit and the current MDS nurse came after this error. The Administrator stated she expected the MDS to be complete and accurately coded. 2. Resident #44 was admitted on 05/02/17 with diagnoses including cerebral infarction, anxiety disorder, hemiplegia and peripheral vascular disease. Review of the admission Minimum Data Set (MDS) dated 05/12/17 coded her as cognitively intact and toileting activities had not occurred. Interview with the MDS nurse on 09/08/17 at 11:15 AM revealed she began completing MDS assessments in June 2017. She stated she could not account for the inaccurate coding of toileting for Resident #44, however, she has been training the nurse aides on the correct coding of activities of daily living skills. Interview with the Administrator on 09/08/17 at 5:07 PM revealed that she was not surprised that errors were found with the MDS coding. She revealed that she had trained a MDS staff person and wanted to provide more education, however,	F 278	On 9/25/17, the MDS for resident #44 with an ARD of 5/12/17, was modified by the MDS nurse to provide a more accurate assessment of the resident's toileting needs. The assessment dated 5/12/17, indicated toileting had not occurred. An interview with staff and the resident revealed that resident #44 requires assistance with toileting. The coding was modified to give a more accurate assessment of the resident's toileting needs. Using an audit tool, on 9/29/17, the MDS nurse completed a review of MDS assessments completed in the past 90 days, section G regarding toileting, to ensure the MDS had been coded accurately. Assessments will be modified as indicated by 10/3/17 by the MDS nurse. The MDS nurse will begin an in-service regarding the accurate coding of Activities of Daily Living (ADL) to include toileting for all Certified Nursing Assistants (CNA) to be completed by 9/27/17. Using an audit tool on 10/2/17, the MDS nurse will begin a review of the electronic medical record with special focus on the ADL documentation entered by the CNA's to ensure the documentation demonstrates an accurate description of the actual needs of the residents. The MDS nurse will review 50% of residents during the look back period prior to the ARD regarding ADL documentation x 4 weeks then 25% x 4 weeks to identify any staff who need re-training.	

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	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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F 278	Continued From page 37 she quit and the current MDS nurse came after this error. The Administrator stated she expected the MDS to be complete and accurately coded.	F 278	The audit tools will be reviewed monthly by the Executive QI Committee for identification of potential trends and development of plans of action and need for continued monitoring.	
F 279 SS=E	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 279		10/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 38 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and resident and staff interviews the facility failed to develop a comprehensive care plan which included specific and individualized approaches for 3 of 3 residents (Resident #79, #52, #27) at risk for weight loss and 1 of 1 resident (Resident #62) reviewed for discharge planning. The findings included:	F 279	F 279 The position of Magnolia Lane Nursing and Rehabilitation Center regarding the process that led to this deficiency was the staff failed to follow established facility policy and protocol. Individualized care plans were developed	

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F 279	Continued From page 39 1. Resident #79 was admitted to the facility on 07/03/17 with diagnoses of non-Alzheimer's dementia, diabetes and thyroid disorder. Review of the admission Minimum Data Set (MDS) dated 07/11/17 revealed Resident #79 was cognitively intact. Review of the Care Area Assessment (CAA) for Nutrition revealed nutrition would be care planned. An interview conducted on 09/08/17 at 11:20 AM with the MDS Nurse revealed the Registered Dietician (RD) completed section K of the MDS and the nutrition CAA. The MDS stated if the Nutrition CAA said to go to care plan a care plan should have been developed. She further stated the RD was responsible for the nutrition care plans. An interview conducted on 09/08/17 at 2:18 PM with the RD revealed she completed the CAA for Nutrition for Resident #79 and intended to care plan nutrition. She stated she should have developed a care plan for nutrition for Resident #79 but had overlooked it. An interview conducted with the Director of Nursing on 09/08/17 at 4:15 PM revealed it was her expectation for care plans to be developed if the CAA stated it would be care planned. 2. Resident #52 was admitted to the facility on 06/11/17 with diagnoses of diabetes, hyperlipidemia and high blood pressure. Review of the admission Minimum Data Set (MDS) dated 06/17/17 revealed Resident #52 was cognitively intact. Review of the Care Area	F 279	for residents #27, 52 and 79 by the MDS nurse on 10/2/17 to address nutritional status and the risk for weight loss. An individualized care plan was developed for resident #62 by the MDS nurse on 10/2/17 to address discharge planning. Using an audit tool, the MDS nurse will complete a 100% audit of resident's at risk for weight loss and plans for discharge from the facility based on the Care Area Assessment (CAA) to ensure the nutritional status and discharge care plans are in place to include interventions by 10/3/17. The Interdisciplinary Care Plan Team (MDS nurse, Social Worker, Dietary Manager and Activity Director) will be in-serviced by the Administrator regarding the need to develop care plans for any resident at risk for weight loss and plans for discharge to include appropriate interventions. On 10/1/17, using an audit tool, the MDS nurse will begin reviewing 100% of resident CAA's x 4 weeks then 50% of resident CAA's x 4 weeks to ensure a care plan is in place for all residents at risk for weight loss or have plans to discharge from the facility. The audit tools will be reviewed at the monthly Executive QI Committee meeting to ensure the facility maintains implemented procedures and monitors these interventions for continued compliance.	

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F 279	Continued From page 40	F 279		

Assessment (CAA) for Nutrition revealed Resident #52 should proceed to care plan for nutrition.

An interview conducted on 09/08/17 at 11:20 AM with the MDS Nurse revealed the Registered Dietician (RD) completed section K of the MDS and the nutrition CAA. The MDS stated if the Nutrition CAA said to go to care plan a care plan should have been developed. She further stated the RD was responsible for the nutrition care plans.

An interview conducted on 09/08/17 at 2:18 PM with the RD revealed she completed the CAA for Nutrition for Resident #52 and intended care plan nutrition. She stated she should have developed a care plan for nutrition for Resident #52 but had overlooked it.

An interview conducted with the Director of Nursing on 09/08/17 at 4:15 PM revealed it was her expectation for care plans to be developed if the CAA stated it would be care planned.

3. Review of Resident # 27's medical record revealed he was admitted to the facility on 06/19/17 with diagnoses that included diabetes mellitus and hyperlipidemia.

Review of Resident #27's admission Minimum Data Set (MDS) dated 06/26/17 revealed his cognition was moderately impaired, his speech was clear and he could understand others. The MDS also noted that he required supervision with eating and received a therapeutic diet.

Review of Resident #27's Care Area Assessment (CAA) for Nutrition dated 06/28/17 and completed

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F 279	Continued From page 41	F 279		

by the Registered Dietician (RD) indicated a care plan for nutrition would be developed.

On 09/08/17 at 11:20 AM an interview with the MDS Nurse revealed the (RD) completed section K of the MDS and the Nutrition CAA. The MDS Nurse stated if the Nutrition CAA indicated to proceed to care plan then a care plan should have been developed. The MDS Nurse further stated the RD was responsible for the nutrition care plans.

An interview conducted on 09/08/17 at 2:18 PM with the RD revealed she completed the nutrition CAA for Resident #27 and intended to write a care plan for nutrition but had overlooked it.

During an interview with the Director of Nursing on 09/08/17 at 4:27 PM revealed it was her expectation for the RD to have written a nutrition care plan for Resident #27.

4. Resident #62 was admitted to the facility on 06/07/16 with diagnoses including chronic obstructive pulmonary disease, congestive heart failure, end stage renal disease, hypertension and major depressive disorder.

His admission Minimum Data Set (MDS) dated 06/14/16 coded him as having intact cognition, being independent with bed mobility, transfers, walking, and toileting. He was coded as requiring limited assistance with dressing, set up and supervision eating, set up for hygiene care and limited assistance with bathing. He was coded as being continent of bowel and bladder and expected to be discharged to the community. He was currently participating in therapy.

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	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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F 279	Continued From page 42	F 279		

The quarterly MDSs dated 09/14/16, 12/09/16, 03/11/17 and annual dated 06/09/17 all coded him with intact cognition and having a discharge plan in place.

Review of the care plans for Resident #62 revealed no care plan related to discharge planning.

The only mention of a discharge to the community was mentioned in a social note dated 02/14/17 when the resident asked about the progress she was making related to the agency which was to help financially. No details were noted in this note.

Resident #62 stated on 09/05/17 at 10:28 AM that he had signed up for a community program to assist him financially to transition to independent living. He stated he has not heard anything since early last month and was wondering what was the status of him discharging to the community. He stated he did not need skilled nursing care and wanted to move on.

A follow up interview with Resident #62 on 09/08/17 at 1:27 PM revealed last December 2016 he went through the process to obtain aid to help him transition to independent living. He stated he was currently waiting for an open apartment.

Interview with the MDS nurse on 09/08/17 at 11:15 AM verified there was no discharge care plan in the medical record for Resident #62. MDS nurse stated that the Social Worker enrolled him in a program and they were waiting for an open apartment.

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F 279	Continued From page 43 A phone interview was conducted with the SW on 09/08/17 at 12:10 PM. The SW stated she did not know what a discharge care plan was. Once explained, the SW stated she had not developed a discharge care plan for him going to the community. She stated the application was approved for housing in 3 counties. Interview with the Director of Nursing on 09/08/17 at 2:42 PM revealed she expected a discharge care plan to be developed for Resident #62 since he had been planning on discharging to the community since admission. Interview with the Administrator on 09/08/17 at 5:07 PM revealed that she looked at Resident #62's medical record and agreed there was no discharge plan in place and one should have been developed.	F 279		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.	F 280		10/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 44 (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 45 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and resident interviews, the facility failed to include 1 of 3 sampled residents to participate in the care plan process (Resident #20). The findings included: Resident #20 was admitted to the facility on 09/06/13 with diagnoses including dysphagia, compression fractures, major depressive disorder, chronic pain, heart failure, chronic respiratory failure and hemiplegia. His most recent Minimum Data Set (MDS) an annual dated 07/08/17 coded him with intact cognition, multiple mood indicators, requiring	F 280	F 280 The position of Magnolia Lane Nursing and Rehabilitation Center regarding the process that led to this deficiency was staff failed to follow established facility policy and protocol. On 9/24/17, resident #20 attended a care plan meeting with the MDS nurse, Director of Nursing, Social Worker, Rehab Manager, Activity Director and Dietary Manager to review the plan of care. Using an audit tool, the Administrator will do a 100% audit of residents and/or	

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F 280	Continued From page 46 supervision and set up for bed mobility, transfers, walking, dressing eating toileting and hygiene. He was coded as being unsteady during transitions but could stabilize himself. The Mood Care Area Assessment dated 07/14/17 indicated he recently lost his wife and had no family support. On 09/05/17 at 11:19 AM, during an interview, Resident #20 stated he was not included in any decisions about his care or medicines. He stated he took about 46 pills a day and did not feel he talked to physician enough and did not get invited to care plan meetings. Interview with the Social Worker on 09/07/17 at 2:48 PM revealed that the MDS nurse presented her with a schedule of upcoming care plans to schedule. The Social Worker then called families and offered a day for a care plan meeting per their convenience. She stated she also has offered telephone conferences if a mutual time to meet was delayed. She further stated that she invited the residents to care plan meetings explaining that families had also been invited. On the day of the care plan meetings, she stated she invited the resident again. The Social Worker stated that she used a form that the participants sign as attending. She further stated that Resident #20 was his own responsible party and always attended his care plan meetings. On follow up interview with Resident #20 on 09/08/17 at 8:57 AM, Resident #20 stated he did not attend care plan meetings and had not been invited. When told that staff were saying that he was invited he stated "baloney."	F 280	responsible parties to ensure that each resident or representative had an opportunity to review the care plan of the resident either in person or via telephone. Any residents requesting a care plan review, will be scheduled by 10/4/17 at a date/time to accommodate the resident and/or responsible party. The Social Worker will utilize a form to track and manage a care plan schedule to ensure that residents and/or responsible parties are invited to review the care plans at least quarterly. The Interdisciplinary Team, to include the MDS nurse, Social Worker, Activity Director and Dietary Manager will receive an in-service by the Administrator on 10/2/17 on the Care Plan process. The audit tool will be reviewed at the monthly Executive QI Committee meeting to ensure the facility maintains implemented procedures and monitors the interventions for continued compliance.	

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	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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F 280	Continued From page 47 A telephone interview with the Social Worker on 09/08/17 at 12:06 PM revealed that they used a paper to sign for the interdisciplinary care plan meeting. She stated Resident #20 usually attended his care plan meetings and not sure where the form would be. She could not recall if he had been to his last care plan meeting but stated he was coming due for one. Review of the care plan documentation provided revealed, Resident #20 was listed on the schedule for a care plan meeting the week of 07/16/17 but there was not specific date or time. Interview with the Administrator on 09/08/17 at 9:21 AM revealed she could locate any other evidence that Resident #20 was invited to a care plan meeting after 02/21/17. An interview was conducted with the MDS nurse on 09/08/17 at 11:15 AM. MDS nurse stated that the Social Worker generally leads the care plan meetings. She further stated that she did not recall attending a care plan meeting since she became the MDS nurse in May 2017 for Resident #20.	F 280		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced	F 282		10/6/17

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F 282	Continued From page 48 by: Based on record review and resident and staff interviews the facility failed to follow the care plan for the number of desired showers per week for 2 of 7 residents reviewed for choices (Residents #35, #7). The findings included: 1. Resident #35 was admitted to the facility on 03/12/11 with current diagnoses of paraplegia and traumatic brain injury. Review of the quarterly Minimum Data Set (MDS) dated 07/10/17 revealed Resident #35 was moderately cognitively impaired and required extensive assistance for personal hygiene and bathing. Review of the care plan dated 07/18/17 revealed Resident #35 required assistance with bathing related to impaired mobility, physical limitations (refuses baths at times). The goal was for Resident #35 to be neat, clean and odor free through the next review. The interventions included: one person to provide physical assist for bathing. Encourage resident to participate in self-care as ability permits. Prefers showers three times a week. Review of the facility shower schedules from 07/2016 to present revealed Resident #35 received one to two showers per week with no documented refusal of shower's. An interview conducted on 09/05/17 at 2:49 PM with Resident #35 revealed he wanted more showers per week than he was receiving. Resident #35 stated he was supposed to receive	F 282	F 282 The position of Magnolia Lane Nursing and Rehabilitation Center regarding the process that led to this deficiency was staff failed to follow established facility policy and protocol. On 9/20/17, residents #35 and #7 care plans and resident care guides were reviewed and updated by the MDS nurse to reflect the resident's bathing preferences of 3 showers per week. The shower schedule was updated on 9/20/17 by the Director of Nursing to reflect resident #35 and #7 bathing preferences. Residents #35 and #7 received showers on 9/9/17, 9/12/17 and 9/15/17 as requested. On 9/29/17, the Director of Nursing completed an in-service of 100% of nursing staff regarding the need to follow the resident care plans and care guides to provide care as preferred by the residents or responsible parties. During orientation of new employees, nurses and Certified Nursing Assistants will be educated on the importance of following the resident's care plan and care guides On 9/20/17, the MDS nurse, using an audit tool, began reviewing resident care plans and care guides to ensure bathing preferences of the residents or responsible parties was being followed. 10% of residents will be reviewed weekly	

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F 282	Continued From page 49 three showers per week and some weeks he only received one. An interview conducted on 09/07/17 at 11:45 AM with Nurse Aide (NA) #1 revealed they have a shower schedule book and each resident received two showers per week. She stated Resident #35's shower's days were Wednesday and Saturday and she did not recall him ever refusing his showers. She stated she was not aware Resident #35 wanted three showers per week. NA #1 stated they have shower book that tells them what days resident showers were due. She stated they have care guides for each resident but Resident #35's care guide did not indicate he wanted 3 showers per week. During an interview on 09/08/17 at 2:05 PM the Director of Nursing (DON) stated she was not sure what system the facility had in place for assessing residents' preference regarding how many showers they wanted every week. The DON further stated if Resident #7 requested and was care planned for 3 showers every week she should be scheduled for 3 showers a week. An interview with the Administrator on 09/08/17 at 5:25 PM revealed the facility should revisit choices for showers for all residents and also provide residents with the number of showers specified on their plan of care. 2. Resident #7 was admitted on 11/30/11 with diagnoses including dementia. Review of a quarterly Minimum Data Set (MDS) dated 07/05/17 revealed Resident #7 had severely impaired cognitive skills for daily decision and was able to make her needs known.	F 282	x 4 weeks then 10% monthly for 3 months to monitor for continued compliance. The audit tools will be reviewed at the monthly Executive QI Committee meeting to ensure the facility maintains implemented procedures and monitors the interventions for continued compliance.	

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F 282	Continued From page 50	F 282		

She was totally dependent on staff with bathing.

Review of a care plan for activities of daily living revised on 06/23/17 revealed Resident #7 was required assistance with bathing related to her cognitive impairment, impaired mobility, and physical limitations. Interventions included total dependence on one person with bathing and the resident preferred showers 3 times a week.

Review of the shower schedule revealed Resident #7 was scheduled to receive showers every Wednesday and Saturday during the 1st shift (7:00 AM to 3:00 PM).

During an interview on 09/05/17 at 12:19 PM Resident #7's Responsible Party stated she received 2 showers a week but he would like for her to have three a week. The family member did not recall anyone ever asking how many showers Resident #7 preferred weekly.

During an interview on 09/08/17 at 2:05 PM the Director of Nursing (DON) stated she was not sure what system the facility had in place for assessing residents' preference regarding how many showers they wanted every week. The DON indicated she was not aware Resident #7 was care planned for three showers a week. The DON further stated if Resident #7 requested and was care planned for 3 showers every week she should be scheduled for 3 showers a week.

An interview with the Administrator on 09/08/17 at 5:25 PM revealed the facility should revisit choices for showers for all residents and also provide residents with the number of showers specified on their plan of care.

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F 309	Continued From page 51	F 309		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		10/6/17

483.24 Quality of life
Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:

(k) Pain Management.
The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:

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F 309	Continued From page 52 Based on observations, record reviews, and staff and Nurse Practitioner interviews the facility failed to elevate a resident's legs to decrease edema per the Nurse Practitioner's order for 1 of 3 sampled residents reviewed for care to maintain well being (Resident #26). The findings included: Review of the medical record revealed Resident #26 was admitted on 11/17/16 with diagnoses including coronary artery disease (CAD), heart failure, and hypertension. Review of the significant change Minimum Data Set (MDS) dated 07/05/17 revealed Resident #26 had severely impaired cognition, was able to make her needs known and understand others. The significant change MDS indicated Resident #26 required extensive assistance with transfer and ambulating did not occur. Her mobility device was listed as a wheelchair. Review of a progress note dated 08/30/17 revealed Resident #26 was seen by the Nurse Practitioner (NP) for an acute visit to evaluate edema in her bilateral ankles. The NP documented Resident #26 was currently prescribed Lasix (a diuretic) 40 mg (milligrams) twice a day which was controlling the congestive heart failure but she continued to have bilateral edema beginning at the ankles and extending to her toes. The NP noted Resident #26 appeared to keep her feet in a dependent position unless she was resting in bed. The NP explained in the progress note she would discuss elevating Resident #26's legs as much as possible when she was sitting as well as the use of the compression hose.	F 309	F 309 The position of Magnolia Lane Nursing and Rehabilitation Center regarding the process that led to this deficiency was the nursing staff failed to follow established facility procedure to provide care services for the highest well-being of the resident. From 9/8/17-9/12/17, the Director of Nursing made multiple attempts to encourage resident #26 to allow direct care staff to elevate her legs. Resident #26 consistently refused related to having her legs elevated causing discomfort to her knees. On 9/12/17, the Nurse Practitioner was notified of the refusals and discontinued the order to elevate her legs. Using copies of actual physician telephone orders, on 10/2/17, the Director of Nursing will complete a 100% audit of orders written in the past 30 days to ensure that physician and nurse practitioner orders are communicated and completed according to established facility expectations and policy including documentation on the care plan or care guide. The Director of Nursing and Staff Facilitator will complete an in-service on 10/2/17 for 100% of nursing staff regarding communication and completion of physician orders to include documentation on the care guide for direct care staff.	

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F 309	Continued From page 53 Review of the medical record revealed an order from the NP dated 08/30/17 for compression hose and to keep legs elevated when sitting in chair to keep down edema. Review of Resident #26's August 2017 and September 2017 Medication Administration Records revealed a handwritten FYI (for your information) notation which stated keep legs elevated. Review of Resident #26's care guide in her closet and her information on the nurse aide (NA) communication sheets (JOT sheets) revealed elevating her legs was not listed. Observations of Resident #26 on 09/05/17 at 10:45 AM and 3:15 PM revealed she was sitting in her wheelchair (WC) her without her legs elevated. On 09/06/17 at 10:51 AM, 2:16 PM, and 4:07 PM Resident #26 was observed sitting in her WC without her legs elevated. Observations on 09/07/17 at 8:43 AM and 11:15 AM revealed she was sitting in her WC without her legs elevated. On 09/08/17 at 9:54 AM revealed Resident #26 was sitting in her WC without her legs elevated. The resident was wearing compression hose and shoes during all of the observations and as a result she could not be assessed for edema. An interview was conducted with the NP on 09/08/17 at 1:42 PM. The NP stated she thought Resident #26's edema was due to dependency and it was not realistic for her to stay in bed so she wanted her legs elevated when she was up in her chair. The NP further stated the staff had not informed her Resident #26 had been	F 309	All telephone orders will be reviewed 5 x per week by the Director of Nursing, Staff Facilitator, MDS nurse and Treatment nurse to ensure that all orders involving direct care staff are transcribed onto the resident care guide. Using an audit tool, the Director of Nursing, MDS nurse and Staff Facilitator will observe 3 residents per day x 4 weeks to ensure care is being provided according to the resident care guide. Using a Department Manager QI round tool, each scheduled day, the Department managers will make rounds of assigned rooms to ensure preferences documented on the resident care guides are being followed by direct care staff. The audit tools will be reviewed at the monthly Executive QI Committee meeting to ensure the facility maintains implemented procedures and monitors interventions for continued compliance.	

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F 309	Continued From page 54	F 309		

noncompliant with this intervention for the edema and she would have expected for her legs to be elevated.

During an interview on 09/08/17 at 1:57 PM the Director of Nursing (DON) stated the hall nurse was responsible for signing off orders and transcribing them to the MAR. The DON indicated orders to elevate legs was most often written on the resident's MAR as an FYI and sometimes this type of care information was added to the NAs JOT sheets. The DON further stated she had not thought about adding this type of information to the care guide for the nurse aides (NAs) located in the residents' closet. In addition, the DON noted that all new orders were reviewed during the weekday morning meetings but she was not sure what interventions the MDS Nurse added to the care plans and they did not always discuss what should be care planned. The interview further revealed the DON expected Resident #26's legs to be elevated when she was up in her chair if there was an order from the NP.

An interview with NA #4 and NA #5 on 09/08/17 at 2:22 PM revealed they were assigned to Resident #26's hall and were working together. NA #4 and NA #5 both stated they had been told by the nurse Resident #26 had an order for compression hose and they had been putting them on every morning but neither of them had been informed she needed to have her legs elevated. NA #4 indicated this type of care information was sometimes placed on the JOT sheets or the care guides in the residents' closet.

During an interview on 09/08/17 at 2:30 PM the MDS Nurse stated she recalled the team discussed Resident #26 and the order

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F 309	Continued From page 55 compression hose and elevating her legs during a recent morning meeting. The MDS Nurse stated she would not necessarily put these interventions on the care plan if they were not going to be used long term. The interview further revealed this type of information was typically put on the NAs JOT sheets which were updated by the Administrator and DON or the care guides in the residents' closet. An interview with the Administrator on 09/08/17 at 5:31 PM revealed all new orders were taken to and reviewed during the weekday morning meetings. When asked about the order to elevate Resident #26's legs the Administrator stated she thought the administrative nurses should have clarified the order with the NP because she was not sure if Resident #26 would be compliant with this intervention. The interview further revealed the Administrator expected orders written by the NP and Physician to be followed and communicated to staff.	F 309		
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and	F 323		10/6/17

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F 323	Continued From page 56 maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain the wooden hall handrails in smooth condition and free of chips and splintered areas on 2 of 2 current units being currently used (Central and Main) presenting an accident hazard. The findings included: During an environmental tour of the Central and Main halls on 09/05/17 between 12:45 PM and 12:51 PM, the wooden hand rails were observed to have chips and splintered areas on the corners and edges in the following areas: a. by room 84; b. on both sides of room 86; c. by room 87; d. by room 88 e. on both sides of the shower room; f. by the solarium; g. by drinking fountain across from the nursing station; h. by room 94; i. by room 95; j. on both sides of room 96;	F 323	F 323 The position of Magnolia Lane Nursing and Rehabilitation Center regarding the process that led to this deficiency was the staff failure to report areas needing repair and not following established facility protocols. On 9/20/17, the Maintenance Director repaired the wood hand rails that had chips and splintered areas on the corners and edges in the following areas: A. by room 84 B. On both sides of room 86 C. By room 87 D. by room 88 E. On both sides of the shower room F. By the solarium G. By the drinking fountain across from the nurse's station H. by room 94 I. By room 95 J. On both sides of room 96 K. By room 97 L. By room 98 M. by room 99 N. On both sides of the Main Hall dining room O. On both sides of the time clock and across from the Main Hall dining room P. by room 101 Q. by room 104 R. by the Oxygen storage	

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F 323	Continued From page 57 k. by room 97; l. by room 98; m. by room 99; o. on both sides by the Main hall dining room; p. on both sides by the time clock and across from the main dining room; q. by room 101; r. by room 104; s. by the oxygen storage room across from room 104; t. by room 107; u. by room 108; and v. by the Central hall dining room. On 09/08/17 at 3:05 PM the Maintenance Director stated he made weekly rounds and completed work orders daily. He further stated that he checked the handrails daily and if he observed an issue he addressed it. The Administrator who was present during the interview with the Maintenance Director on 09/08/17 at 3:05 PM and added that the housekeepers also wipe off the handrails every day and should report problems to the Maintenance Director. Following another observational tour of the handrails on 09/08/17 at 3:45 PM with the Maintenance Director, Housekeeping Supervisor and Administrator, the Administrator stated that the edges of the handrails were chipped especially in the high traffic areas.	F 323	room across from room 104 S. by room 107 T. by room 108 U. by the Central Hall dining room Using an audit tool, on 9/25/17, the Maintenance Director completed a 100% audit of all handrails to ensure no chips or splintered areas were present. On 9/30/17, the Administrator completed a 100% staff in-service regarding the need to report to the Maintenance Director using a work order form any wood hand rails that had chips or splintered wood immediately to avoid an accident/hazard to our resident or staff. Using an audit tool, the Maintenance Director will make rounds of the facility 5 x per week x 4 weeks to check all hand rails to ensure there are no chips or splintered areas present. Any chips or splintered areas identified will be repaired immediately by the Maintenance Director as indicated. After 4 weeks, using a Maintenance QI Round tool, the Administrator will make weekly rounds of the facility to monitor handrails for chips and splintered areas with immediate notification to the Maintenance Director for repair to prevent injury to staff, visitors and/or residents. The audit tools will be reviewed monthly by the Executive QI Committee to ensure the facility maintains implemented procedures and monitors these interventions for continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332 SS=D	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff, Pharmacist, and Physician interviews, the facility failed to be free of a medication error rate greater than 5% as evidenced by 3 errors out of 27 opportunities, resulting in a medication error rate of 11.1% for 1 of 4 residents observed during medication administration (Resident #21). The findings included: Review of the medical record revealed Resident #21 was admitted on 09/10/14 with diagnoses including chronic obstructive pulmonary disease (COPD), hypertension, and diabetes mellitus. Review of Physician's orders for September 2017 revealed Resident #21's prescribed medication included Advair diskus inhaler 250/50 mcg (micrograms) one puff twice a day with instructions to rinse the resident mouth with water after administering, Metformin (oral diabetic medication) 500 mg (milligrams) twice a day with instructions to give with food, and Metoprolol Tartrate (used to treat atrial fibrillation and hypertension) 37.5 mg 2 tablets twice a day. 1.a. During an observation of medication administration on 09/06/17 from 10:57 AM until 11:19 AM Nurse #3 was observed preparing Resident #21's medications which included an	F 332	F 332 The position of Magnolia Lane Nursing and Rehabilitation Center regarding the process that led to this deficiency was the nursing staff failure to follow established facility policy to provide medication error rate of 5% or less. On 9/8/17, the Director of Nursing notified the Nurse Practitioner regarding the medication errors occurring on 9/6/17 by Nurse #3 involving resident #21 and #26. No adverse reactions occurred related to the medication errors. The Director of Nursing and Staff Facilitator will complete an in-service by 10/3/17 for all Medication Aides, LPN's and RN's on the correct method to administer an Advair Inhaler, medications ordered with food/meals and the standard procedure of following the 5 Rights of Medication Administration with special focus on the correct dosage of medications. Using a Medication Pass Audit form, the Director of Nursing and Staff Facilitator will complete one Medication Pass audit	10/6/17

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	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

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F 332	Continued From page 59 Advair diskus inhaler 250/50 mcg at 10:57 AM. Nurse #3 entered Resident #21's room at 11:16 AM and administered the Advair inhaler after the oral medications. Nurse #3 did not give Resident #26 a cup of water and ask her to rinse and spit out the water after administering the Advair. She exited the room at 11:19 AM and returned to the medication cart. During an interview on 09/06/17 at 11:24 AM Nurse #3 confirmed she was finished with Resident #21's medication administration. When asked if she was trained to do anything after administering an Advair inhaler Nurse #3 stated she should have had Resident #21 rinse her mouth with water after the Advair inhaler was administered and had forgotten to do so. b. During an observation of medication administration on 09/06/17 from 10:57 AM until 11:19 AM Nurse #3 was observed preparing Resident #21's medications which included a Metformin 500 mg tablet at 10:57 AM. Nurse #3 entered Resident #21's room at 11:16 AM and administered the Metformin along with her other oral medications. Nurse #3 did not bring a snack or offer any food to Resident #26 before or after administering the Metformin. She exited the room at 11:19 AM and returned to the medication cart. An interview was conducted with Nurse #3 on 09/06/17 at 2:36 PM. When asked if there were any specific instructions included in the order for Resident 21's Metformin Nurse #3 consulted Resident #21's MAR and stated the medication should be given with food. Nurse #3 confirmed she had not given Resident #21 any food with the Metformin that morning and indicated she usually	F 332	on each Medication Aide, LPN and RN monthly beginning 10/1/17 for 3 months. Re-training will be provided as indicated. The Medication Pass Audit forms will be reviewed at the monthly Executive QI Committee meetings to ensure the facility maintains implemented procedures and monitors these interventions for continued compliance.	

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	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

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F 332	Continued From page 60	F 332		

gave Resident #21 her medications closer to breakfast but she was running behind this morning.

c. During an observation of medication administration on 09/06/17 from 10:57 AM until 11:19 AM Nurse #3 was observed preparing Resident #21's medications which included Metoprolol Tartrate 37.5 mg one tablet at 10:57 AM. Nurse #3 entered Resident #21's room at 11:16 AM and administered the Metoprolol Tartrate along with her other oral medications. Nurse #3 exited the room at 11:19 AM and returned to the medication cart.

An interview was conducted with Nurse #3 on 09/06/17 at 2:36 PM. Nurse #3 reviewed Resident #21's September 2017 Medication Administration Record during the interview and confirmed she had made an error and only administered one tablet of Metoprolol Tartrate 37.5 mg that morning instead of two tablets per the Physician's order.

An interview with the Pharmacist on 09/07/17 at 10:30 AM revealed Metformin should be given with food due to concern of hypoglycemia when not given with food. The Pharmacist noted the instructions on the MAR clearly stated to rinse the Resident #21's mouth with water after administering Advair and to give the Metformin with food. The interview further revealed the Pharmacist expected the nurse to administer Resident #21 two tablets of Metoprolol Tartrate 37.5 mg as specified on the MAR.

During an interview on 09/08/17 at 10:20 AM the Physician stated he expected the nurses to do the best job possible but did not expect

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	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

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F 332	Continued From page 61 perfection. The Physician further stated Metformin and Metoprolol were both long acting drugs which decreased the possibility of negative outcome to Resident #21. He indicated rinsing a resident's mouth with water after administering Advair helped to prevent thrush (fungal infection). An interview with the Director of Nursing (DON) on 09/08/17 at 2:11 PM revealed Nurse #3 should have rinsed Resident #21's mouth after administering the Advair to help prevent thrush and also given her a snack with the Metformin to prevent hypoglycemia because she had not administered it with a meal. The DON stated Resident #21 should have been administered the Metoprolol Tartrate per the Physician's order.	F 332		
F 353 SS=E	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by	F 353		10/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 353	Continued From page 62 sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews and resident interviews, the facility failed to provide enough staff to provide showers as scheduled for 3 residents (#20, #59, and #78), provide treatment for skin tears for 1 resident (#41), and providing medications in a timely manner (Resident #21 and #15). The findings included: 1. Resident #78 was admitted to the facility on	F 353	F 353 The position of Magnolia Lane Nursing and Rehabilitation Center regarding the process that led to this deficiency was the facility failed to communicate effectively the staffing needs to provide sufficient 24 hour nursing staff per care plans. 1. On 9/9/17, resident #78 was provided a shower by the certified nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

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F 353	Continued From page 63 06/01/17 with diagnoses of a fractured ankle, chronic kidney disease, hypertension and diabetes. The admission Minimum Data Set (MDS) dated 06/14/17 coded her with a brief interview for mental status score of an 11 out of 15 indicating moderately impaired cognition. The quarterly MDS dated 08/26/17 showed she had no cognitive impairments. On 09/05/17 at 11:38 AM, Resident #78 stated during an interview that she was not given a choice as to how many showers or baths she would like each week. She stated they scheduled two showers per week and she does not always get 2 showers per week. Ideally she stated she would want a shower daily. During follow up interview on 09/07/17 at 11:58 AM, Resident #78 she stated she only received one shower a week and didn't think there was enough staff. Review of the shower documentation revealed since 07/01/17 she received a shower as follows: a. 3 in July 2017 on 07/02/17, 07/07/17 and 07/15/17; b. 2 in August 2017 on 08/08/17, 08/11/17 and she was on the list for 08/29/17 but no initials or note indicating the shower was provided; c. in September 2017 she was showered on 09/01/17 and again on the list for 09/04/17 but no initials to document that a shower was offered and or given. On 09/08/17 at 2:35 PM the Director of Nursing stated that she was aware that residents were not	F 353	assistant. 2. On 9/9/17, resident #20 was provided a shower by the certified nursing assistant. 3. On 9/9/17, resident #59 was provided a shower by the certified nursing assistant. 4. Resident #41 received treatments as ordered thru 9/5/17 to the left upper arm. Treatment to left upper arm discontinued on 9/6/17-healed. Resident #41 received treatment to coccyx 9/5 and 9/6/17. Treatment to coccyx discontinued on 9/7/17-healed. Treatments to right lower leg and left forearm on-going with no missed treatments noted. 5. Utilizing Agency certified nursing aides began in June to decrease staff to resident ratio improving call light response, ensuring residents are receiving showers as preferred and medications being administered timely 6. The Director of Nursing will stagger medication administration times on 10/1/17 per the Pharmacy consultant recommendation dated 8/27/17 to ensure residents are receiving medications within the time perimeters they are ordered Daily, the scheduler and the Director of Nursing review the schedule to ensure sufficient numbers of staff are scheduled to provide nursing care to all residents to include assisting with Activities of Daily living (ADL's) such as showers, call lights, administering medications according to the recommended timeframes and provide and document treatments according to physician/nurse practitioner orders. Agency staffing is utilized to cover shortages when available.	

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	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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MAGNOLIA LANE NURSING AND REHABILITATION CENTER	107 MAGNOLIA DRIVE MORGANTON, NC 28655

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F 353	Continued From page 64 getting their showers consistently. She stated the facility was having some staffing issues. She further stated that if a resident refused a shower, the nurse aide was to get the nurse to assist. She stated she reconfigured the sheets to ensure each staff knew the schedule and if there was no documentation on the shower sheet, the shower was probably not given. 2. Resident #20 was admitted to the facility on 09/06/13 with diagnoses including dysphagia, chronic pain, heart failure, chronic respiratory failure, chronic obstructive pulmonary disease, and hemiplegia. His annual Minimum Data Set dated 07/08/17 coded him with having intact cognition. Resident #20 stated on 09/05/17 at 11:15 AM during interview that he does not have a choice as to how many showers he gets per week. Resident #20 stated that he would prefer a shower every day and that would never happen. He then stated they asked him his choices but they definitely do not follow wishes mainly because there was not enough staff. He stated he was promised 2 showers per week and only gets 2 showers a week "once in a great while" which he related was due to short staffing. Review of the shower documentation since 07/01/17 revealed: a. In July 2017 he received a shower on 07/02/17 and 07/15/17; b. In August 2017 he was showered on 08/08/17, was scheduled for 08/11/17 but no initials were next to his name to indicate he was offered or given a shower; he refused a shower on 08/14/17; and he was showered on 08/18/17 and	F 353	Using an audit tool, on 9/29/17, the Director of Nursing completed a shower audit to ensure that for the past 7 days, each resident had received showers as they desired. No residents reported complaints of not receiving showers or baths as they preferred. Using an audit tool, on 9/29/17, the Director of Nursing audited 100% of resident treatment administration records for the past 7 days to ensure that no resident had missed an ordered treatment. No missed treatments were identified. Using an audit tool, on 9/29/17, the Administrator interviewed all interviewable residents regarding call light response. The scheduler and Director of Nursing will continue daily review of the staffing using the Daily Staffing sheet. Agency nursing (CNA's and licensed nurses) will be utilized to cover any shortages indefinitely to provide adequate coverage to meet the needs of the residents. The Director of Nursing, Staff Facilitator, QI Nurse and MDS will review the electronic medical record/shower sheets, Medication Administration Records and Treatment Administration Records before the end of each shift 5 x per week x 4 weeks to ensure showers were given, medications were given and treatments were completed. The Social Worker and QI nurse will interview 5 residents per week x 4 weeks to determine if any	

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	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

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F 353	Continued From page 65 08/30/17. Although no shower sheets were provided for September 2017, he was observed coming out of the shower on 09/06/17 at 4:00 PM. On 09/08/17 at 2:35 PM the Director of Nursing stated that she was aware that residents were not getting their showers consistently. She stated the facility was having some staffing issues. She further stated that if a resident refused a shower, the nurse aide was to get the nurse to assist. She stated she reconfigured the sheets to ensure each staff knew the schedule and if there was no documentation on the shower sheet, the shower was probably not given. 3. Resident #59 was most recently admitted on 01/13/17 with diagnoses of dysphagia, diabetes, peripheral vascular disease and cerebral infarction. Her last three quarterly Minimum Data Sets dated 01/20/17, 04/19/17 and 07/13/17 coded her as having intact cognition and no behaviors. During an interview on 09/07/17 at 12:02 PM, Resident #59 stated that the 2 showers scheduled per week was fine with her, however, she stated that she does not get 2 showers a week. She stated that she did not get a shower last week and no shower thus far this week. Resident #59 indicated sometimes staff would explain that there was only one nurse aide on and then they expected the next shift to pick up missed showers. She further stated that you could complain all you want but it had done no good so she quit complaining and tried to clean herself the best she can.	F 353	residents are dissatisfied with bathing preference, medication administration times, treatment omissions or prolonged call light response times. Any concerns expressed will be documented on a facility Concern/Grievance form with an investigation per facility protocols. The audit tools will be reviewed monthly by the Executive QI Committee to ensure the facility maintains implemented procedures and monitors these interventions for continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

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F 353	Continued From page 66	F 353		

Review of shower documentation from 07/01/17 revealed Resident #59 received the following showers:
a. in July 2017 she was showered on 07/15/17;
b. in August 2017 she was showered 08/09/17, 08/11/17, on 08/18/17 her name was on the shower list but no initials to indicate she received a shower; she received showers on 08/22/17 and 08/29/17;
c. in September 2017 she was on the list for 09/01/17 but there was no initials to indicate she was offered or given a shower.

On 09/08/17 at 2:35 PM the Director of Nursing stated that she was aware that residents were not getting their showers consistently. She stated the facility was having some staffing issues. She further stated that if a resident refused a shower, the nurse aide was to get the nurse to assist. She stated she reconfigured the sheets to ensure each staff knew the schedule and if there was no documentation on the shower sheet, the shower was probably not given.

4. Resident #41 was admitted to the facility most recently on 07/03/12 with diagnoses including hemiplegia, cognitive and social deficits, contractures, dysphagia and chronic pain.

Her quarterly MDS dated 07/22/17 coded her with moderately impaired cognition, requiring extensive to total assistance with most activities of daily living skills, having skin tears, receiving ointments and applications to areas other than feet, and using an anticoagulant 7 times a week.

Review of physician orders included the following skin tear treatments:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 67	F 353		

a. 08/06/17 dry dressing to coccyx twice a day;
b. 08/25/17 start skin prep and Band-Aid to left 2nd digit and change every day;
c. 08/28/17 clean skin tear on right lower leg with wound cleanser apply antibiotic ointment and cover with dry dressing;
d. 08/31/17 clean left elbow with wound cleanser apply TAO and dressing daily; and
e. 08/31/17 clean left forearm with wound cleaner apply TAO and dressing daily.

On 09/07/17 at 10:37 AM, Resident #41 was observed with bandages on her right leg, left forearm, and left elbow. Her coccyx was not observed.

Review of the Treatment Administration Record (TAR) revealed the above orders were not initialed off as being done on 09/05/17 on the 7:00 AM to 7:00 PM shift.

During interview on 09/07/17 at 1:58 PM with Nurse #2 who worked on 09/05/17 revealed she completed the treatments and signed the TAR on the wrong date. She signed on the blanks which she assumed was 09/05/17 but was actually 09/04/17. She further stated she did not work on 09/04/17 where her initials actually were.

Interview with Nurse #4 on 09/07/17 at 3:19 PM revealed she was a new nurse to the facility and stated she did not have time to complete the treatments for Resident #41 on 09/04/17. She stated she was busy doing medication pass and putting out fires. She stated there was not enough staff to complete the medication pass and do treatments. Nurse #4 stated she was hired as the Staff Development Coordinator on 08/20/17 and since orientation, she was being

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

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F 353	Continued From page 68	F 353		

pulled to the floor for nursing duties 2 to 3 times last week and twice this week.

5. Review of grievances revealed ongoing resident voiced concerns related to staffing issues as follows:

*04/18/17 showers are not being given on time or enough times during the week;
*05/02/17 2 residents complained they were not given 2 showers per week;
*05/23/17 2 residents complained they only received one shower each week;
*07/03/17 call lights not being answered with a wait time up to one hour and medications are late;
*07/24/17 staff turn off the call lights with promises to return but they don't; and
*08/08/17 showers are missed and medications are late.

Interview with Nurse #3 on 09/06/17 at 3:44 PM revealed she did not think there was enough staff. She stated it took her around 3 hours to complete the 8:00 AM med pass. She stated she tried to help nurse aides with resident care so she often left medication pass to help a resident who was requesting assistance. She named two residents who she often found wet with urine and attributed that to the nurse aides not having enough time to make rounds.

Interview with Nurse Aide #8 on 09/07/17 at 1:47 PM revealed she used to work for the facility and worked on the Magnolia hall (which is now closed). She stated that when she worked generally 7:00 AM to 7:00 PM she had 30 residents to care for by herself. She stated residents had to wait for call bell response but

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 69	F 353		

she could not say how long as she tried to answer them as fast as she could.

Interview with Nurse Aide #7 on 09/07/17 at 2:00 PM revealed she quit her position due to staffing issues. She stated showers were not able to get completed and when on Magnolia Hall (now closed) she was often responsible for 30 residents by herself. She stated the call lights stayed on a long time and residents often complained about the call bell response.

Interview with Nurse Aide #6 on 09/07/17 at 2:27 PM revealed she worked first and second shifts. She described the typical staffing as 1 nurse aide on Central hall and 2 nurse aides on Main hall. She further stated that not all showers were being completed and that they were to make up missed showers on Saturdays. In addition, she stated residents complained all the time about long call bell responses.

Interview on 09/08/17 at 2:46 PM with the Director of Nursing revealed the facility has been having staffing issues. She stated ideally she wanted 3 nurse aides on the Main unit and 2 nurse aides on the Central unit for first and second shifts. She stated this was not happening consistently as the facility did not have enough staff to pull from. The facility currently had one agency they have used since May 2017 and often that agency does not have the staff to meet the facility's needs. The DON stated that after the schedule was made up the facility sent the agency the openings that needed to be filled and the agency could not always accommodate their needs. The Administrator was working on obtaining another agency contract. She further stated that both she and the Administrator work

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 70	F 353		

as nurse aides in the afternoons to cover openings.

6.a. During an observation of medication administration on 09/06/17 at 11:16 AM Nurse #3 was observed administering Resident #21's medications which included 10 oral medications and an inhaler. The medications were scheduled to be administered at 8:00 AM per the Medication Administration Record (MAR).

An interview with Nurse #3 on 09/06/17 at 2:26 PM revealed she typically administered 8:00 AM medications to the alert residents first and then administered medications to the remaining residents on the hall. Nurse #3 stated she had one hour before and one hour after the administration time on the MAR to give the medications. Nurse #3 confirmed she had not administered Resident #21's 8:00 AM medications until after 11:00 AM this morning and stated the administration time should be changed to 9:00 AM. The interview further revealed she could not always get the medications administered in time because if a resident asked her for help with something she could not say no to them.

b. During an observation of medication administration on 09/07/17 at 11:13 AM Nurse #2 was observed administering Resident #15's medications which included an oral medication mixed in applesauce, eye drops and a patch. The medications were scheduled to be administered at 8:00 AM per the Medication Administration Record (MAR).

An interview with Nurse #2 on 09/07/17 at 3:03 PM Nurse #2 revealed the guidelines for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 71	F 353		

medication administration were one hour before or one hour after the prescribed time. Nurse #2 indicated she could not possibly administer the medications any faster or finish the 8:00 AM medication pass any earlier because there were 32 residents on the hall and all of them had several medications each and the majority had to be crushed. Nurse #2 stated they needed to split the hall and get another nurse or a medication aide to help with the medication pass. She did not think changing the administration times would help.

An interview with the Pharmacist 09/07/17 at 10:30 AM revealed she had shared with the Director of Nursing (DON) that the nurses were not always administering medications within the guidelines of one hour before or after the prescribed time.

During an interview on 09/08/17 at 2:00 PM the Administrator shared a "Medication Pass Audit Form" completed for Nurse #3 by a Pharmacist on 08/28/17. Review of this document revealed there were no errors observed except it was noted medications were not administered within one hour of the prescribed time on the MAR. The comments included that 8:00 AM medications were still being given after 9:00 AM and it was suggested to consider staggering medication pass times. The Administrator stated the main hall was a heavy medication pass but she was not sure if the late administration was across the board. The Administrator further stated Nurse #3 had said the main hall was a heavy medication pass. The interview further revealed the facility had not yet taken action on the Pharmacist's recommendations from 08/27/17. The Administrator did not recall if there had been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 72 comments from the Pharmacist on previous medication pass audits regarding medications not being administered within one hour of the time indicated on the MAR. An interview with the DON on 09/08/17 at 2:11 PM revealed she expected medications to be given one hour before or one hour after the prescribed time on the MAR. The DON stated they had known the main hall was a heavy medication pass for several months but staffing issues had prevented them from having an extra person to pass medications. The DON indicated they would like to get a medication aide for the main hall. The interview further revealed the DON was not sure if the Pharmacist had mentioned the nurses were not always administering medications within the guidelines of one hour before or after the prescribed time to her or not. A follow up interview with the Administrator on 09/08/17 at 5:35 PM revealed the Administrator was not aware the 8:00 AM medications were not getting completed until after 11:00 AM and she stated they needed to get a system place to help with the medication pass. The Administrator explained the goal was to get the number of staff increased so there could be medication aides to help with the 8:00 AM medication pass. The Administrator further stated had just received the Pharmacist's recommendations this week and planned to follow the recommendation to stagger the medication administration times.	F 353		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency	F 431		10/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 73	F 431		

drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 74 have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain medications in a locked treatment cart. This affected 1 of 1 treatment cart in use. The findings included: On 09/06/17 at 8:12 AM the treatment cart was located in the hall and there was no staff around. The cart looked to be missing the locking bar on the side facing the hallway. Within a minute Nurse #1 returned to her cart. In the unlocked side of the treatment cart was a bottle of Dakin's (antiseptic solution made from diluted bleach), a bottle of prescription lotion and antifungal powder. Nurse #1 stated she was the normal treatment nurse and never kept items in the unlocked side as this side of the cart was broken. During follow up interview with Nurse #1 on 09/08/17 at 11:12 AM revealed she started treatments in November 2016. She stated that she used the unlocked side of the cart for bandages only, however, because she was pulled to work as a floor nurse, the treatment cart was being used by all floor nurses when they did their	F 431	F 431 The position of Magnolia Lane Nursing and Rehabilitation Center regarding the process that led to this deficiency was the nursing staff failed to follow established facility policy and protocols. On 9/8/17, the Director of Nursing removed the treatment cart from the hall. All treatment solutions and creams were secured in the Medication Room behind the nurse's station. On 9/9/17, the Maintenance consultant repaired the treatment cart to ensure it locked on both sides. The charge nurses were provided with keys to access the treatment care supplies as needed. On 9/9/17, the Maintenance consultant inspected 2 medication carts and 1 treatment cart to ensure that all locks worked properly to ensure that medications were secured. No other locking mechanisms on carts were in need of repair.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 75 own treatments. She further stated she had not looked inside the broken side of the treatment cart to see if there were any medications being stored there since she never used that side. On 09/08/17 at 2:26 PM, the Director of Nursing stated that the treatment cart should remain locked unless in visual sight of the nurse. She stated she was unaware that the one side of the treatment cart did not lock. She further stated she could not recall any residents ordered on Dakin's solution since she started in February 2017 so she could not tell how long the medications had been stored in the unlocked side of the treatment cart. The Administrator stated during interview on 09/08/17 at 5:07 PM that she was unaware the treatment cart had a one side that did not lock.	F 431	On 9/29/17, the Director of Nursing completed a 100% nursing staff in-service regarding the importance of reporting any medication or treatment carts that failed to lock properly immediately to the Maintenance Director or consultant. Each nurse was instructed that in the event a cart would not lock, the cart was to be locked in the medication room behind the nurse's station until it could be repaired to prevent any residents from accessing medications. Using an audit tool, the Director of Nursing, Staff Facilitator and MDS nurse will check each medication cart and the treatment cart to ensure that all locks are working properly 5 x per week x 4 weeks then 1 x per week x 4 weeks. The audit tools will be reviewed monthly at the Executive QI Committee meeting to ensure the facility maintains implemented procedures and monitors these interventions for continued compliance.	
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F 514		10/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 76 (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview and staff interviews, the facility failed to maintain a complete clinical record for 3 of 30 sampled residents for correct weights and documentation related to discharge planning being provided by the facility (Residents #79, #52, and #62). The findings included: 1. Resident #79 was admitted to the facility on 07/03/17 with diagnoses of anemia, high blood pressure and diabetes.	F 514	F 514 The position of Magnolia Lane Nursing and Rehabilitation Center regarding the process that led to the deficiency was staff failed to follow established facility policy and protocols. On 9/11/17, the Geriatric Care Aide obtained the weight of resident #79 and #52. The weights in comparison to previous weights indicated no sign of weight loss.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 77 Review of the admission Minimum Data Set dated 07/11/17 revealed Resident #79 was cognitively intact and able to make needs known. Review of the weights for Resident #79 revealed the following: 07/03/17 - 181 pounds, 07/10/17 - 167 pounds, 07/13/17 - 167 pounds, 08/02/17 - 170 pounds. Review of the nurse's notes and Registered Dietician (RD) notes revealed no notes related to weight loss from 07/03/17 through 08/02/17. An interview conducted on 09/06/17 at 2:23 PM with the RD revealed she was unaware of the 07/03/17 weight documented in Resident #79's medical record. She stated the first weight she received was for 07/05/17 of 167 pounds. She stated she doesn't always look at weights in the computer medical record but used the weight sheets from the Guest Care Aides (GCAs). An interview conducted on 09/07/17 at 2:33 PM with the Director of Nursing revealed the facility GCAs do all of the weights and give them to the Administrator. She stated they should weigh the resident on admission and then as ordered by the physician. An interview conducted on 09/08/17 at 4:18 PM with the Administrator revealed the GCAs do resident weights and give them to her to monitor. She stated she has had a problem with direct care staff not weighing residents on admission if a GCA isn't working. She stated they take the weight from the hospital discharge which may or may not be correct. The Administrator stated she had addressed this issue with the staff multiple times. She stated the weight entered on 07/03/17	F 514	On 9/20/17, the Social Worker discussed discharge planning with resident #62. The discussion was documented to include progress towards goals to discharge. The MDS nurse added a discharge care plan on 9/20/17. Using an audit tool, 100% of resident weights were completed and reviewed by the Registered Dietician and Dietary Manager to assess for significant weight loss based on the facility policy. The Registered Dietician made recommendations as indicated with appropriate changes to the care plans made by the MDS nurse. Using an audit tool, the Social Worker will complete interviews with all interviewable residents to ensure that each resident appropriate for discharge has a discharge care plan with interventions in place by 10/2/17. Any resident or responsible party expressing a desire to discharge from the facility will have a care plan meeting scheduled by the Social Worker to discuss discharge plans with the resident and/or responsible party attendance. The Staff Facilitator will in-service 100% of nursing staff on obtaining admission weights per facility protocol to be completed by 10/2/17. The Registered Dietician will be in-serviced by the Director of Nursing to utilize the weight in the electronic medical record to complete assessments by 10/3/17.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 78 for Resident #79 was from his hospital discharge record and she had never seen that weight until today and was not aware it had been documented in his medical record. She stated the first weight she received for Resident #79 from the GCAs was on 07/05/17 of 167 pounds. She further stated the weight of 181 pounds on 07/03/17 was not correct and should not have been documented in Resident #79's record. 2. Resident #52 was admitted to the facility on 06/11/17 with diagnoses of high blood pressure and diabetes. Review of the Admission Minimum Data Set (MDS) dated 06/17/17 revealed Resident #52 was cognitively intact. Review of the weights for Resident #52 revealed the following: 06/14/17 - 149 pounds, 06/15/17 - 143 pounds, 06/22/17 - 144 pounds, 07/10/17 - 145 pounds, 08/02/17 - 124 pounds, 08/30/17 - 140 pounds. Review of the nurse's notes and Registered Dietician (RD) notes revealed no notes related to weight loss from 06/11/17 through 08/30/17. An interview conducted on 09/06/17 at 2:33 PM with the RD revealed she saw the weight of 124 pounds recorded on 08/02/17 during her visit on 08/12/17 and made a note to obtain a re-weight. She stated the weight of 124 pounds had to be documented wrong due to Resident #52 eating well and having no significant weight loss during her stay in the facility. An interview conducted on 09/07/17 at 2:33 PM with the Director of Nursing revealed the facility	F 514	On 10/2/17, the Social Worker will be in-serviced by the Administrator on the discharge process and the need for accurate documentation in the electronic medical record regarding the status of the discharge plan with a discharge care plan in place. Using an audit tool, the Dietary Manager will audit 5 medical records weekly x 4 weeks, then 3 medical records weekly x 4 weeks to ensure weights, to include admission weights are correctly documented in the electronic medical record. Review of resident weights will continue indefinitely by the Director of Nursing, Dietary manager, MDS nurse and QI nurse weekly at Weight meetings to identify any residents at risk of weight loss for interventions to be put into place. Using an audit tool, the MDS nurse will review 5 medical records per week x 4 weeks to ensure discharge planning is being documented in the electronic medical record and a care plan is in place. The audit tools will be reviewed at the monthly Executive QI Committee meeting to ensure the facility maintains implemented procedures and monitors these interventions for continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 79	F 514		

Guest Care Aides (GCAs) do all of the weights and give them to the Administrator. She stated they should weigh the resident on admission and then as ordered by the physician.

An interview conducted on 09/08/17 at 4:18 PM with the Administrator revealed the GCAs do resident weights and give them to her to monitor. The Administrator stated the weight for Resident #52 had been documented wrong and a re-weight should have been done.

3. Resident #62 was admitted to the facility on 06/07/16 with diagnoses including chronic obstructive pulmonary disease, congestive heart failure, end stage renal disease, hypertension and major depressive disorder.

His admission Minimum Data Set (MDS) dated 06/14/16 coded him as having intact cognition, being independent with bed mobility, transfers, walking, and toileting. He was coded as requiring limited assistance with dressing, set up and supervision eating, set up for hygiene care and limited assistance with bathing. He was coded as being continent of bowel and bladder and expected to be discharged to the community. He was currently participating in therapy.

The quarterly MDSs dated 09/14/16, 12/09/16, 03/11/17 and annual dated 06/09/17 all coded him with intact cognition and having a discharge plan in place.

Review of the care plans for Resident #62 revealed no care plan related to discharge planning.

The only mention of a discharge to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 80	F 514		

community was mentioned in a social note dated 02/14/17 when the resident asked about the progress she was making related to the agency which was to help financially. No details were noted in this note.

Resident #62 stated on 09/05/17 at 10:28 AM that he had signed up for a community program to assist him financially to transition to independent living. He stated he has not heard anything since early last month and was wondering what was the status of him discharging to the community. He stated he did not need skilled nursing care and wanted to move on.

A follow up interview with Resident #62 on 09/08/17 at 1:27 PM revealed last December 2016 he went through the process to obtain aid to help him transition to independent living. He stated he was currently waiting for an open apartment. He also stated that he was given the option to present other apartments he found i.e. in the newspaper and that he had given them to the social worker for follow up.

A phone interview was conducted with the social worker on 09/08/17 at 12:10 PM. She stated the application was approved for housing in 3 counties. He was on a waiting list. She stated that when she called other apartments presented to her from Resident #62, they did not accept the subsidized payment. She stated that she had a lot of emails with the case worker about the program, his application, acceptance and what they were waiting on. She was out of town and could not produce them for the survey.

On 09/08/17 at 12:17 PM a phone interview was conducted with the case worker for the housing

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	345219	A. BUILDING _____ B. WING _____	C 09/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 81 program. She explained that Resident #62 was made aware of the long wait for the apartments which had to accommodate his income, a bus route for dialysis appointments, any handicap needs and being close to his family. She confirmed that the social worker had been in contact via emails multiple times throughout this process. Interview with the Administrator on 09/08/17 at 5:07 PM revealed that she looked at the record and agreed there was no documentation related to the ongoing process to discharge Resident #62 to the community. She expected a discharge care plan ad notes to show progress towards his discharge.	F 514		
F 520 SS=E	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must :	F 520		10/6/17

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F 520	Continued From page 82 (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility's Quality Assessment and Assurance Committee failed to develop and implement interventions and procedures to stay in compliance for 4 deficiencies cited during the recertification survey of 07/21/16 and recited during this recertification of 09/08/17. The repeated deficiencies were in the areas of environment, accuracy of assessments, and medication storage. These deficiencies during 2 federal surveys of record show a pattern of the facilities inability to implement an effective Quality assurance Program. The findings included: This tag is crossed referred to:	F 520	F 520 The position of Magnolia Lane Nursing and Rehabilitation Center regarding the process that led to this deficiency was failure to follow established facility policy and protocols. On 10/5/17, the facility will hold an Executive QI Committee meeting. The Medical Director, Administrator, Director of Nursing, Social Worker, MDS nurse, Staff Facilitator, Maintenance Director, Activity Director and Housekeeping Supervisor will attend Executive QI Committee meetings on an on-going basis and will assign additional team	

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F 520	Continued From page 83 1. F 253: Based on observations and staff interviews, the facility failed to maintain a clean and sanitary environment by keeping personal items labeled, covered and off the floor, keeping floors free of stains and in good repair, keeping caulking around toilets clean and intact, keeping the shower room with clean grout and tiles secured to the floor, and keeping walls and door frames painted and free of scaring. This affected rooms accessible to 36 of 54 residents in the facility. The facility was originally cited during a recertification survey of 07/21/16 for failure to properly store personal care equipment. During an interview on 09/08/17 at 6:00 PM the Administrator stated after the survey of 07/21/16, they put up shelving in the bathrooms so that would keep personal equipment off of the floors which was what she considered the main issue. She did not expect wash basins to be covered but she did expect everything to be labeled and off of the floor. 2. F 278: Based on record review and staff interviews, the facility failed to accurately assess 2 of 30 sampled residents for toileting abilities. Residents #41 and #44's toileting abilities were coded as not having occurred during their assessments. The facility was originally cited during the recertification survey of 07/21/16 for diagnoses not being accurately coded on the Minimum Data Sets (MDS). During an interview with the Administrator on	F 520	members as appropriate. On 9/29/17, the corporate facility consultant in-serviced the Administrator, Director of Nursing, Social Worker/Admissions Coordinator, Maintenance Director, Staff Facilitator, Activity Director, Dietary Manager, Housekeeping Supervisor, Rehab Manager and MDS nurse regarding the appropriate functioning of the QI Committee and the purpose of the committee to include the identification of issues related to F 253-Maintenance to maintain a sanitary, orderly and comfortable interior, F278-Accuracy of Assessments and F431-Storage of drugs/biologicals in locked compartments. As of 10/2/17, after the facility consultant in-service, the facility QI Committee will begin identifying other areas of quality concern through the QI review process, for example: review of audit tools, review of work orders, review of Point Click Care (Electronic Medical Record), resident council minutes, resident concern logs, pharmacy reports and regional facility consultant recommendations. The facility QI Committee will meet monthly to identify issues related to quality assessment and assurance activities as needed will develop and implement appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to	

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F 520	Continued From page 84 09/08/17 at 6:00 PM, she stated the previous MDS nurse from last year left and they hired, trained and retrained another who also recently left resulting in accuracy issues. 3. F 431: Based on observations and staff interviews, the facility failed to maintain medicines in a locked treatment cart. This affected 1 of 1 treatment cart in use. The facility was originally cited during the recertification survey of 07/21/16 for not maintaining the correct temperature in a medication refrigerator and not disposing of expired medications. During an interview with the Administrator on 09/08/17 at 6:00 PM, she stated the previous area cited was expired medications and the refrigerator temperatures. The Quality Assurance system was not concentrating on locked medications as this issue was not identified as a problem last year.	F 520	F253-Maintain a safe interior, F278-Accurate assessments and F431-Medication storage. The QI Committee will continue to meet monthly with oversight by a corporate consultant. The QI Committee meeting agenda and minutes with resulting plans of corrections and audit results will be reviewed as a component of this oversight after each QI Committee meeting. The Executive QI Committee, including the Medical Director, will review monthly compiled QI report information, review of trends and review of corrective actions taken and the dates of completion. The Executive QI Committee will validate the facility's progress in correction of deficient practices or identify concerns. The Administrator will be responsible for ensuring Committee concerns are addressed through further training or other interventions. The Administrator or designee will report back to the Executive QI Committee at the next scheduled meeting.	