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 12/15/2017

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 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		1/12/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/12/2018

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

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F 580	Continued From page 1 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record reviews, staff, and physician interviews the facility failed to notify the supervising Physician when a resident missed 8 doses of intravenous (IV) antibiotics as ordered for 1 of 3 residents sampled for provide pharmaceutical services (Resident #2). The findings included: Resident #2 admitted to the facility on 10/27/17 and discharged from the facility on 11/27/17. Resident #2's diagnoses included: aortic valve endocarditis (inflammation of the heart valve), acute pulmonary disease, and others. Review of the most recent comprehensive minimum data set (MDS) dated 11/03/17 revealed that Resident #2 was cognitively intact and required limited assistance with activities of daily living. The MDS further revealed that Resident #2 received intravenous (IV) medications during the reference period. Review of a facility document titled "Final Report: Outpatient Antimicrobial Therapy Orders" (OATO) dated 10/27/17 which accompanied Resident #2 to the facility. The OATO order sheet indicated	F 580	F580 Magnolia Lane Nursing and Rehabilitation Center acknowledges receipt of The Statement of Deficiencies and Purposes 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 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 Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. The plan of correcting the specific	

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Continued From page 2

that the Physician supervising the IV antibiotic therapy was Physician #1 and Resident #2 was to receive Ampicillin (antibiotic) 2 grams (gm) IV every 4 hours until 11/26/17. The discharge plan read in part, contact the supervising physician with questions regarding antimicrobial therapy, delay in therapy for any reason, and difficulty with IV access (including limb swelling), adverse drug reactions, fever greater than 100.4 degrees, or symptoms of deep vein thrombosis.

Review of the Medication Administration Record (MAR) dated 10/27/17 through 10/30/17 revealed the following: Ampicillin 2 mg per 100 milliliters (ml) IV every 4 hours. The MAR revealed that Resident #2 did not receive the Ampicillin until 12:00 AM on 10/29/17 and had missed 8 doses of Ampicillin between 10/27/17 and 10/28/17.

An interview was conducted with the Staff Development Coordinator (SDC) on 12/14/17 at 11:08 AM. The SDC confirmed that she had transcribed the orders for Resident #2 on admission and then faxed them to the pharmacy. The SDC stated that she was not aware that Resident #2 had missed the 8 doses of Ampicillin on admission and stated that someone should have contacted the pharmacy to request an extra delivery so the IV ampicillin could have initiated timely. In addition to the pharmacy someone should have contacted Physician #1 and made him aware of the delay in therapy.

An interview was conducted with Nurse #2 on 12/14/17 at 12:32 PM. Nurse #2 confirmed that she was working on the main unit where Resident #2 resided on 10/28/17 from 7:00 AM to 7:00 PM. Nurse #2 stated that the orders were sent to the pharmacy on 10/27/17 and thety were waiting for

F 580

deficiency

The position of Magnolia Lane Nursing and Rehabilitation center regarding the process that lead to this deficiency-failed to notify the supervising physician when a resident missed 7 doses of intravenous antibiotics as ordered- was the staff failure to follow established policy for physician notification of missed medication doses (medication error) related to knowledge deficit.

Resident #2 was discharged to the community on 11/27/17 with home health and follow-up with physician on outpatient basis.
The procedure for implementing the acceptable plan of correction for the specific deficiency cited

On 1/10/18 the facility consultant completed an audit of December 2017 and January medication administration records for residents receiving intravenous medications (IV) through 1/10/18 to ensure any missed medication doses were communicated to the physician and orders obtained if appropriate. No negative findings were noted.
On 1/10/18 the facility consultant in-serviced the director of nursing, staff facilitator, and the minimum data set nurse on the medication error policy (including IV medications) which includes notification of physician.
All licensed nurses will be in-serviced by 1/12/18, including agency and new hires

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F 580 Continued From page 3

the medication to arrive at the facility from the pharmacy. Nurse #2 confirmed that she had not administered the IV ampicillin because she did not have it to give. She added that she had not asked the pharmacy to make a special delivery and had not contacted Physician #1 for any additional orders.

An interview was conducted with Physician #1 on 12/14/17 at 3:54 PM. Physician #1 stated that Resident #2 was being treated for endocarditis and it was imperative that she receive a full 6 week course of IV antibiotic therapy. Physician #1 stated that the facility had contacted him in mid-November about Resident #2 missing a dose of IV antibiotics due to the national shortage of IV bags and he had offered to readmit Resident #2 to the hospital or try to obtain the medication from somewhere else. He added that the facility's pharmacy was able to dispense the medication and he had to increase the length of her therapy to cover those missed doses. However Physician #1 stated that he was not aware that Resident #2 had missed an additional 8 doses of medication on admission to the facility. Physician #1 stated that Resident #2 had surgery on 10/16/17 and full 6 week course of IV therapy was needed. He stated that the missed doses were very concerning to him and he certainly would have wanted to have been notified but stated the only thing he could have done would have been to extend the course of her treatment. Physician #1 stated that he had seen Resident #2 on 12/04/17 and she was doing well and at this point he did not think there was anything further that needed to be done because Resident #2's blood cultures were clear. He stated that all things considered he did not think the missed doses affected her outcome but did add he would plan to follow her a

F 580

by the director of nursing or staff facilitator on notifying the physician if an IV medication dose is missed based on the medication error policy. In-service will include documentation of notification, and physician orders if appropriate.
The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements

The director of nursing, staff facilitator, facility consultant, and/or minimum data set nurse will audit 100% of medication administration records weekly for 4 weeks then 50% per week for 8 weeks to ensure any missed IV medication doses are communicated to the physician and orders obtained as appropriate. This audit will be documented on the Medication Administration Audit tool.
The monthly QI committee will review the results of the medication audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.

The title of the person responsible for implementing the acceptable plan of correction.

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F 580	Continued From page 4 little longer in the outpatient setting to make sure that nothing came up. An interview was conducted with the Direct of Nursing (DON) on 12/15/17 at 1:50 PM. The DON confirmed that she was working the Main unit on 10/27/17 from 7:00 AM to 7:00 PM when Resident #2 admitted to the facility. She stated that the SDC had taken care of the orders and faxed them to the pharmacy and they had waited for the delivery that would arrive between 2:00 AM and 4:00 AM on 10/28/17. The DON confirmed that she had not contacted the pharmacy to request the IV medication be delivered sooner and was not aware that Resident #2 had missed 8 doses on admission to the facility. The DON added that she also would have expected the staff to contact Physician #1 and make him aware of the 8 missed doses on admission to the facility.	F 580	The Director of nursing is responsible for implementing the acceptable plan of correction.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(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	F 656		1/12/18

F 656 Continued From page 5 F 656

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not 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 observations, record reviews, family, and staff interviews the facility failed to implement care plan interventions by not applying protective geri sleeves (Resident #16) for 1 of 3 residents sampled for care plans.

The finding included:

Resident #16 was readmitted to the facility on 12/30/15 and her diagnoses included: contracture of hand and elbow, dementia, Alzheimer's disease, and others.

F656

The plan of correcting the specific deficiency

The position of Magnolia Lane Nursing and Rehabilitation center regarding the process that lead to this deficiency-failure to implement care plan interventions- was staff failure to follow the established procedure in reviewing the resident care plan including care guide related to

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F 656	Continued From page 6 Review of the most recent minimum data set (MDS) dated 09/12/17 revealed that Resident #16 was severely cognitively impaired for daily decision making and required extensive to total assistance from staff for all activities of daily living. Review of care plan revised on 09/12/17 read in part, Resident #16 was at risk for skin breakdown or development of further pressure ulcers. The goal of the stated care plan was Resident #16 would not develop any new pressure ulcers. The interventions included: geri sleeves to bilateral upper extremities for skin protection. Review of the care guide located in Resident #16's closet stated: geri sleeves to bilateral upper extremities. An observation was made of Resident #16 on 12/13/17 at 11:45 AM. Resident #16 was resting in bed with eyes open and she had a soft left elbow splint in place. No protective geri gloves were in place. An interview was conducted with Nursing Assistant (NA) #8 on 12/13/17 at 3:37 PM. NA #8 confirmed that she routinely cared for Resident #16 which included 12/13/17. NA #8 stated that Resident #16 required total assistance with all activities of daily living and staff had to anticipate her needs. She added that someone had applied her soft left elbow splint that morning but she was not aware that she was to have geri sleeves on as well. An observation was made of Resident #16 on 12/14/17 at 11:00 AM. Resting #16 was resting in	F 656	communication deficit. Resident #16 had protective geri-sleeves applied by certified nursing assistant (CNA) on 1/10/18. Resident # 16 bilateral arms were assessed by the director of nursing on 1/10/18 for skin issues including bruising, and skin tears with no negative findings. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 1/10/18 the facility consultant completed an audit of current resident care plans to ensure residents with protective geri-sleeves as an intervention had them in place with no negative findings noted. On 1/10/18 the facility consultant in-serviced the director of nursing, staff facilitator, and the minimum data set nurse on placement of the resident care guide to facilitate CNA communication, and updating of the resident care guide to meet current resident status. All licensed nurses and CNAs will be in-serviced by 1/12/18, including agency and new hires by the director of nursing, staff facilitator, or minimum data set nurse on location of the care guide, following interventions listed including protective geri-sleeves, and actions to take if care guide is not accurate or supplies not available to provide care. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory	

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F 656	Continued From page 7 bed. No protective geri gloves were in place. An interview was conducted with Nurse #2 on 12/14/17 at 12:32 PM. Nurse #2 stated that she expected the NAs to review each residents care guide prior to providing care and to implement the interventions that were listed on that care guide each day. An interview was conducted with NA #5 on 12/14/17 at 3:13 PM. NA #5 confirmed that she routinely cared for Resident #16 which included 12/14/17. NA #5 stated that she had reviewed Resident #16's care guide prior to providing care and did not see the geri sleeves listed, she added that she may have overlooked them. NA #5 confirmed that she had not applied the geri sleeves on 12/14/17. She added that she believed that she saw Resident #16 wear them months ago but not recently. An interview was conducted with Resident #16's family member on 12/14/17 at 4:17 PM. The family member stated that she visited her loved one 3 to 4 times a week. The family member further stated that her loved one was supposed to wear the protective geri sleeves to her bilateral upper extremities and they were in the closet and have not been worn in months. She added "I do not think any knows to use them." The family member further stated that orders were not followed through because lack of staff training and the staff did not stay long enough to learn the needs of the residents. An observation was made of Resident #16 on 12/14/17 at 5:22 PM. Resident #16 was resting in bed with her family at bedside. No protective geri gloves were in place.	F 656	requirements The director of nursing, staff facilitator, facility consultant, and/or minimum data set nurse will audit 50% of residents weekly for 4 weeks, then 25% of residents per week 8 weeks with intervention of geri-sleeves to ensure intervention is in place. This audit will be documented on the Care Plan Audit Tool. The monthly QI committee will review the results of the medication audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Director of nursing is responsible for implementing the acceptable plan of correction.	

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F 656	Continued From page 8 An observation was made of Resident #16 on 12/15/17 at 12:04 PM. Resident #16 was resting in bed and had a soft left elbow splint in place. No protective geri gloves were in place. An interview was conducted with NA #7 on 12/15/17 at 12:09 PM. NA #7 confirmed that he routinely provided care to Resident #16 including 12/15/17 and he had not applied the geri gloves and actually had never applied them to Resident #16. NA #7 stated he had seen them a while ago in her closet but not recently. He added that he was not aware that the protective geri sleeves were on Resident #16's care guide as he had not reviewed it on 12/15/17. An interview was conducted with the Director of Nursing (DON) on 12/15/17 at 1:50 PM. The DON stated that she had not seen Resident #16 with geri sleeves on in months. She added that she would expect the nursing staff to implement care plan interventions as directed by the care plan on a daily basis.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, resident and staff interviews the facility failed to provide showers as scheduled (Resident #1), and failed to provide oral care (Resident #9) for 2 of 5 residents sampled for activities of daily living.	F 677	F677 The plan of correcting the specific deficiency	1/12/18

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The findings included:

1. Resident #1 was initially admitted to the facility on 06/13/16 and most recently readmitted to the facility on 12/11/17. Her diagnoses included: malignant neoplasm of breast, hyperlipidemia, bipolar disorder, and hypertension.

Review of the most recent quarterly minimum data set (MDS) dated 09/15/17 indicated that Resident #1 was cognitively intact and required extensive assistance of one staff member with bathing. No behaviors or rejection of care was identified on the MDS.

Review of a facility document titled "Daily Nursing Jot Sheets" indicated that Resident # 1 was scheduled for a shower on Tuesdays, Fridays, and Sundays on 1st shift.

Review of the facility's shower documentation revealed the following:

Friday 12/01/17: Resident #1 received a shower.

Sunday 12/03/17: Resident #1 did not receive a shower.

Tuesday 12/05/17: Resident #1 did not receive a shower.

Friday 12/08/17: Resident #1 did not receive a shower.

Sunday 12/10/17: Resident #1 did not receive a shower.

Tuesday 12/12/17: Resident #1 received a

F 677

The position of Magnolia Lane Nursing and Rehabilitation center regarding the process that lead to this deficiency-failure to provide showers as scheduled and failed to provide oral care- was the staff failure to follow established policy for resident bathing, and procedure for oral hygiene related to communication deficit.

Resident #1 was provided a shower by certified nursing assistant (CNA) on 1/10/18.
Resident # 9 was provided oral care be CNA on 1/10/18.
The procedure for implementing the acceptable plan of correction for the specific deficiency cited

On 1/10/18 the facility consultant reviewed showers for the past 7 days. Negative findings were addressed by 1/12/18 by facility consultant, CNA staff, or director of nursing.
On 1/10/18 and 1/11/18 the facility consultant completed an audit of current residents oral care status with no negative findings.
New shower schedule developed on 1/11/18 by the facility consultant based on facility obtained resident preferences.
On 1/12/18 the new shower schedule was placed at each nursing station in labeled notebook for access by CNA staff.
On 1/10/18 the facility consultant in-serviced the director of nursing, staff facilitator, and the minimum data set nurse on new shower schedule, shower documentation, shower policy, and oral care procedure.

F 677 Continued From page 10
shower.

Friday 12/15/17: Resident #1 did not receive a shower.

An interview was conducted with Nurse #2 on 12/14/17 at 12:32 PM. Nurse #2 stated that the Nursing Assistants (NAs) did not report which showers they were not able to complete, she added that they reported that to the Director of Nursing (DON). Nurse #2 stated that they did not turn any shower sheets into her but she had 1 agency NA that would always report when a resident would refuse. She added that some days there were 12 showers scheduled for 2 NAs to complete and that was not possible. The NAs had to feed the residents then provide care and by the time they finished care it was time for lunch and another round before the end of their shift and that left no time for showers. Nurse #2 stated that the NAs try to catch up the showers on the next day but that generally did not happen.

An interview and observation was conducted with Resident #1 on 12/15/17 at 10:30 AM.Resident #1 was resting in bed with eyes open, her hair was very shiny and appeared very oily. She was dishelved and there was a slight body odor detected in the her room. Resident #1 stated that she had not had a shower thus far on 12/15/17 and had not received a shower on 12/10/17, 12/08/17, 12/05/17, and 12/03/17. She added that her showers were "hit or miss and sometimes they had enough staff to complete my shower but most days they did not." Resident #1 stated that sometimes they would wash her off in the sink in her room but she really preferred to go to the shower and get really clean in her abdominal fold which sometimes caused a foul odor.

F 677

All licensed nurses and CNAs will be in-serviced by 1/12/18,including agency and new hires. by the director of nursing, staff facilitator, or minimum data set nurse on the new shower schedule (including location), shower documentation, shower policy, and oral care procedure.
The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements

The director of nursing, staff facilitator, facility consultant, and/or minimum data set nurse will audit 20 residents weekly for 4 weeks, then 10 residents per week 8 weeks to ensure showers were given per schedule and oral care is satisfactory. This audit will be documented on the Resident Care Audit Tool.
The monthly QI committee will review the results of the medication audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.

The title of the person responsible for implementing the acceptable plan of correction.
The Director of nursing is responsible for

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F 677	Continued From page 11 An interview was conducted with NA #4 on 12/15/17 at 11:55 AM. NA #4 confirmed that she was working with Resident # 1 on 12/10/17 and was unable to complete her scheduled shower. She added that it was a common occurrence to not complete all the scheduled showers because there was just not enough staff to help us get them all done. NA #4 stated that they reported to the Nurses at the end of their shift which showers were not completed and they generally told us to try and catch them up on the next day. NA #4 stated that the facility used to have a shower team that would complete the scheduled showers each day but that went away because they did not have enough staff. An attempt to interview NA #6 was made on 12/15/17 at 12:00 PM and was unsuccessful. NA #6 was working with Resident #1 on 12/03/17. An interview was conducted with NA # 5 on 12/15/17 at 3:13 PM. NA #5 confirmed that she was working with Resident #1 on 12/15/17, 12/08/17, and 12/05/17 and was not able to complete Resident #1's showers on those days. She added that on 12/15/17 she was responsible for completing 5 showers and she was not able to get them done during her shift. NA #5 stated that the facility did not have enough NAs to get everything that they wanted done and we have told them and told them but it had not improved any. She added that when they were unable to complete the showers they told the Nurses and they would tell us to try and do them the next day but we have showers that were already scheduled for the next day and just do not have time to do any extra.	F 677	implementing the acceptable plan of correction.	

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F 677	Continued From page 12	F 677		

An interview was conducted with the DON on 12/15/17 at 1:50 PM. The DON stated that she expected the showers to be completed as scheduled but she was aware that was not feasible given the very limited staff they had. She added that if 3rd shift was able to help with some of the showers that would help but they could not help when there was only 2 NAs in the building at night so they really do the best they can.

2. Resident #9 was admitted to the facility on 06/01/17 with diagnoses which included hypertension, chronic kidney disease and diabetes mellitus type 2.

Review of the most recent quarterly minimum data set (MDS) dated 11/06/17 indicated Resident #9 was cognitively intact and required extensive assistance of 2 persons for personal hygiene. No behaviors or rejection of care were identified on the MDS.

An interview and observation was conducted with Resident #9 on 12/13/17 at 10:58 am. Resident #9 was resting in bed with her eyes open and watching TV. The resident stated that she "could not remember the last time staff assisted her with brushing her teeth." Resident #9 had a film on her teeth and particles of food were noted in the base of her upper and lower gums. She stated she did not like the slimy feeling of her teeth. The resident's toothbrush and toothpaste were noted to be on her bedside table and available for use.

An interview and observation was conducted with Resident #9 on 12/13/17 at 4:00 pm and she stated the staff still had not assisted her with brushing her teeth. Resident #9s teeth still had a film on them and there were particles of food still

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F 677	Continued From page 13	F 677		

noted in the base of her upper and lower gums.

An interview and observation was conducted with Resident #9 on 12/14/17 at 8:56 am and she stated the staff still had not assisted her with brushing her teeth. Resident #9s teeth still had a film on them and there were particles of food still noted in the base of her upper and lower gums.

An interview was conducted with Nursing Assistant (NA) #7, an agency NA on 12/14/17 at 3:56 pm. NA #7 stated he had taken care of Resident #9 all week and he had not assisted her with oral care. NA #7 stated he had not been able to provide oral care because he had been the only NA on the unit for 17 residents.

An interview with Nurse #3 on 12/14/17 at 4:02 pm revealed she was an agency nurse, had only been working at the facility for 3 days and was trying to get acclimated to the residents and their needs. Nurse #3 stated she was not aware that Resident #9 had not had oral care.

An interview and observation was conducted with Resident #9 on 12/14/17 at 5:00 pm and she stated the staff still had not assisted her with brushing her teeth. Resident #9's teeth still had a film on them and there were particles of food still noted in the base of her upper and lower gums.

An interview was conducted with the Director of Nursing (DON) on 12/15/17 at 1:50 pm. The DON stated that she expected oral care to be completed with morning care but she was aware that was not feasible given the very limited staff they had in the facility. She added that the staff working all three shifts do the best they can but she would expect all residents to be provided

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F 677	Continued From page 14 assistance with oral care.	F 677		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. 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). §483.35(a)(1) The facility must provide services by 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. §483.35(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. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, family and staff interviews the facility failed to provide nursing staff of sufficient quantity to provide showers and oral care. This affected 2 out of 5 residents (Resident #1 and Resident #9).	F 725	F725 The plan of correcting the specific deficiency	1/12/18

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F 725	Continued From page 15 The findings included: This tag is cross reference to F:677: Based on observations, record reviews, resident and staff interviews the facility failed to provide showers as scheduled (Resident #1) and failed to provide oral care (Resident #9) for 2 of 5 residents sampled for activities of daily living. An interview and observation was conducted with a family member on 12/13/17 at 12:50 PM. The family member was observed brushing his loved ones teeth. The family member stated he visited his loved one everyday around lunch time, he added that he always brushed her teeth because they never got brushed any other time. He added that he also cleaned the matter out of her eyes, the food from under her fingernails, applied lip balm, and filled her water pitcher up while he was there. The family member stated that there was absolutely no continuity of care and the agency staff that the facility utilized did not know the residents. The family member stated he had spoken to the many different Administrators and Director of Nursing but nothing had improved. An interview was conducted with the Regional Ombudsman on 12/13/17 at 2:56 PM. She stated she had reports consistently that there was no continuity of care at the facility. She added that the turnover rate was high amongst the administrative staff and really all over which drove a lot of the staffing concerns that were reported to her. She stated that at present she had no open cases but would receive random calls about the staffing issues within the facility.	F 725	The position of Magnolia Lane Nursing and Rehabilitation center regarding the process that lead to this deficiency-failed to provide nursing staff of sufficient quantity to provide showers and oral care-was communication of staff needs to ensure staff were following the policy for showers, and procedure for oral care. Resident #1 was provided a shower by certified nursing assistant (CNA) on 1/10/18. Resident # 9 was provided oral care be CNA on 1/10/18. On 1/10/18 the administrator reviewed staffing for 1/10/18 and scheduled staff for the next 7 days. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 1/10/18 the facility consultant reviewed showers for the past 7 days. Negative findings were addressed by 1/12/18 by facility consultant, CNA staff, or director of nursing. On 1/10/18 and 1/11/18 the facility consultant completed an audit of current residents oral care status with no negative findings. New shower schedule developed on 1/11/18 by the facility consultant based on facility obtained resident preferences. On 1/10/18 the administrator in-serviced the director of nursing, staff facilitator, and scheduler on staffing expectations including ensuring showers are completed per policy, and oral care completed per procedure.	

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F 725

Continued From page 16

An interview was conducted with Nurse #2 on 12/14/17 at 12:32 PM. Nurse #1 stated that the facility was short staffed and had been for some time. She added that at times the Nursing Assistants (NAs) had 12 showers to give and that was not reasonable to expect 2 NAs to complete that many in one 8 hour shift. She added that she had recruited a couple of nurses but they did not stick around for one reason or another but the management team told us that no one was applying for the open positions.

An interview was conducted with a family member on 12/14/17 at 4:17 PM. The family member stated she visited the facility 3-4 times a week often in the evening and would assist her loved one with eating her supper meal. She added that her loved one was supposed to wear geri sleeves but no one knew that they were supposed to be on her. She stated that orders were not followed through because lack of staff training and the staff did not stay long enough to learn the needs of the residents.

An interview was conducted with Certified Geriatric Assistant (CGA) on 12/14/17 at 5:21 PM. The CGA stated that she was always scheduled 8 hours but always worked 12-16 hours because she did not feel like she could leave the residents with no help.

An interview was conducted with NA #9 on 12/14/17 at 5:45 PM. NA #9 stated that she was agency staff and had been working at the facility for 4-5 months. NA #9 stated that staffing was horrible and she was unable to complete her showers or charting during her shift because there was just not enough time to do it all.

F 725

On 1/10/18 the administrator, and director of nursing determined the number of licensed nurses, CNAs, GCAs, and nursing management staff positions available.
On 1/10/18 the facility consultant in-serviced the director of nursing, staff facilitator, and the minimum data set nurse on new shower schedule, shower documentation, shower policy, and oral care procedure.

Efforts to hire and fill open Licensed Nursing and Certified Nursing Aid Positions are; Facility has contracted with two staffing agencies and communicate their staffing needs to them. Open positions are posted on Career Builder, Indeed, NC Works and other advertising media. Administrator spoke with a representative of NC works to inform them that we will accept applications and hire new graduates with C.N.A certificates when they sponsor clients. Facility is also sponsoring employees at the local college to attend the Certified Nursing Aid Certification classes. Sign-on bonuses are offered for new Nurses and C.N.A□s hired. The facility has started an Employee Recruitment, Retention and Recognition Committee.

All licensed nurses and CNAs will be in-serviced by 1/12/18, including agency and new hires by the director of nursing, staff facilitator, or minimum data set nurse on the new shower schedule (including location), shower documentation, shower policy, and oral care procedure.

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F 725	Continued From page 17 An interview was conducted with the Minimum Data Set (MDS) Nurse on 12/15/17 at 9:49 AM. The MDS nurse stated that staffing was very challenged within the facility, she added that numerous staff have come and gone but rarely do the staff stick around. She added that the scheduler tired very hard to get staff to work but the facility only had 3-4 full time NAs and 1-2 full time Nurses that were employed by the facility and the rest were agency staff. She added that the DON worked the cart and the floor as a NA as recently as 12/14/17. She added that she had come into work to relieve 1 of the full time nurses after that nurse had worked 20 hours in a row. The MDS nurse added that the facility used to have a shower team and offer a restorative program but both have been dissolved due to the staffing shortage. She added that she comes in early in the morning and assist the NAs with rounding and then feeds 4 residents their breakfast before starting her primary duties. An interview was conducted with the Scheduler on 12/15/17 at 12:23 PM. The scheduler stated that staffing consumed her and her time on a daily basis. She stated that the facility had 3 NAs and 1-2 nurses and the rest of the staff were agency staff. The scheduler stated that staffing was not adequate and had not been adequate for some time. She added that the facility could not keep staff and had not hired a staff member since August 2017. The scheduler stated that when staff called in the DON and the Staff development coordinator (SDC) had to fill the spot. The DON frequently worked the medication cart and/or the floor as a NA just to make it through the day. She added that she had 1 agency that she was able to use and she has asked for another one but nothing had happened yet. She added that she	F 725	The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The director of nursing, staff facilitator, facility consultant, and/or minimum data set nurse will audit 20 residents weekly for 4 weeks, then 10 residents per week 8 weeks to ensure showers were given per schedule and oral care is satisfactory. This audit will be documented on the Resident Care Audit Tool. The director of nursing, staff facilitator, administrator, and/or facility consultant will review schedule 5 times per week, to include review of weekend days, times 12 weeks during the morning department head meeting to ensure staff is present to provide shower per policy and oral care per procedure. This review will be documented on the Sufficient Staff Audit tool. The monthly QI committee will review the results of the resident care audit tool and sufficient staff audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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F 725	Continued From page 18 did everything in her power to cover the building but if she could not get anyone it came down to the DON and the SDC. An interview was conducted with the DON on 12/15/17 at 1:50 PM. The DON stated that staffing had definitely gotten worse in the last couple of months. The DON confirmed that 12 times in the last 2 months she had worked the medication cart and/or the floor as a NA. She added that they had 1 agency that they were able to use and on 12/15/17 they received another one. She stated that they were only using agency NAs but had been approved to use Nurses as well. The hall nurses have so much to do and then we ask them to monitor the NAs and that was just not a reasonable expectation. She added that if people would apply then she could hire but stated she currently had no applications to even review. An interview was conducted with the Administrator on 12/15/17 at 4:11 PM. The Administrator stated that staffing had already been identified as an issue when she arrived at the facility just a few days ago. She added that they just received approval of a 2nd staffing agency. The Administrator stated that they had discussed hiring CGAs and then paying for them to go to school to become a NA and also stated that she had a meeting scheduled with a website company to instruct her how to list advertisements on the internet to recruit new employees. An interview was conducted with the Regional Vice President (RVP) on 12/15/17 at 4:24 PM. The RVP stated that he was aware of the staffing issues within the facility and they were actively	F 725	The title of the person responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction.	

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F 725	Continued From page 19 working on them. He stated that the facility recently put the department heads through the feeding assistant class so they could help feed the residents and recently have gained a 2nd staffing agency contract in an attempt to help ease the staffing issues.	F 725		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff, and physician interviews the facility failed to administer intravenous (IV) antibiotics as ordered for 1 of 3 residents sampled for provide pharmaceutical services (Resident #2). The findings included: Resident #2 admitted to the facility on 10/27/17 and discharged from the facility on 11/27/17. Resident #2's diagnoses included: aortic valve endocarditis (inflammation of the heart valve), acute pulmonary disease, and others. Review of the most recent comprehensive minimum data set (MDS) dated 11/03/17 revealed that Resident #2 was cognitively intact and required limited assistance with activities of daily living. The MDS further revealed that Resident #2 received intravenous (IV) medications during the reference period. Review of a facility document titled "Final Report: Outpatient Antimicrobial Therapy Orders" (OATO)	F 760	F760 The plan of correcting the specific deficiency The position of Magnolia Lane Nursing and Rehabilitation center regarding the process that lead to this deficiency-failed to deliver intravenous antibiotics as ordered- was the staff failure to follow policies for obtaining and administering medications due to lack of knowledge. Resident #2 was discharged to the community on 11/27/17 with home health and follow-up with physician on outpatient basis. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 1/11/18 the facility consultant completed an audit of residents on intravenous antibiotics (IV) to ensure	1/12/18

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F 760	Continued From page 20 dated 10/27/17 which accompanied Resident #2 to the facility. The OATO order sheet indicated that the Physician supervising the IV antibiotic was Physician #1 and Resident #2 was to receive Ampicillin (antibiotic) 2 grams (gm) IV every 4 hours until 11/26/17. The discharge plan read in part, contact the supervising physician with questions regarding antimicrobial therapy, delay in therapy for any reason, and difficulty with IV access (including limb swelling), adverse drug reactions, fever greater than 100.4 degrees, or symptoms of deep vein thrombosis. Review of the Medication Administration Record (MAR) dated 10/27/17 through 10/30/17 revealed the following: Ampicillin 2 mg per 100 milliliters (ml) IV every 4 hours. The MAR revealed that Resident #2 did not receive the Ampicillin until 12:00 AM on 10/29/17 and had missed 8 doses of Ampicillin between 10/27/17 and 10/28/17. An interview was conducted with the Staff Development Coordinator (SDC) on 12/14/17 at 11:08 AM. The SDC confirmed that she had transcribed the orders for Resident #2 on admission and then faxed them to the pharmacy. She added that she had not called the pharmacy to request an extra delivery of the medication and the staff administered the medication as soon as it came in from the pharmacy. The SDC stated that she was not aware that Resident #2 had missed the 8 doses of Ampicillin on admission and stated that someone should have contacted the pharmacy to request an extra delivery so the IV ampicillin could have initiated timely. An interview was conducted with Nurse #2 on 12/14/17 at 12:32 PM. Nurse #2 confirmed that she was working on the main unit where Resident	F 760	medication was available in facility for administration as ordered by physician with no negative findings noted. On 1/11/18 the facility consultant in-serviced the director of nursing, staff facilitator, and the minimum data set nurse on the policy for medication ordering, and procurement of emergency and after hour□s medications to ensure medications are available for administration including IV medications. All licensed nurses will be in-serviced by 1/12/18, including agency and new hires by the director of nursing, minimum data set, or staff facilitator on the policy for medication ordering, and procurement of emergency and after hour□s medications to ensure medications are available for administration including IV medications. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The director of nursing, staff facilitator, facility consultant, and/or minimum data set nurse will audit 100% of residents on IV antibiotics weekly for 4 weeks than 25% of residents on IV antibiotics per week for 8 weeks to ensure ordered medications are available. This audit will be documented on the Medication Audit tool. The monthly QI committee will review the results of the medication audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of	

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F 760	Continued From page 21 #2 resided on 10/28/17 from 7:00 AM to 7:00 PM. Nurse #2 stated that the orders were sent to the pharmacy on 10/27/17 and they were waiting for the medication to arrive at the facility from the pharmacy. She stated that when she came to work on 10/28/17 the medication was still not at the facility and she had checked the E-Kit (emergency supply of medication) and the Ampicillin was not in the E-kit and she called the pharmacy and they stated it would be on the next delivery. Nurse #2 confirmed that she had not administered the IV ampicillin because she did not have it to give. She added that she had not asked the pharmacy to make a special delivery and had not contacted the physician for any additional orders she was just waiting for the medication to arrive from the pharmacy and by the time her shift ended it was still not at the facility. An interview was conducted with Physician #1 on 12/14/17 at 3:54 PM. Physician #1 stated that Resident #2 was being treated for endocarditis and it was imperative that she receive a full 6 week course of IV medication and he expected Resident #2 to receive the IV medications as ordered and stated in the OATO form. An attempt to interview Nurse #1 was made on 12/14/17 at 4:26 PM and was unsuccessful. Nurse #1 was working the main unit where Resident #2 resided on 10/27/17 from 7:00 PM to 7:00 AM An interview was conducted with the Direct of Nursing (DON) on 12/15/17 at 1:50 PM. The DON confirmed that she was working the Main unit on 10/27/17 from 7:00 AM to 7:00 PM when Resident #2 admitted to the facility. She stated	F 760	continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Director of nursing is responsible for implementing the acceptable plan of correction.	

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F 760	Continued From page 22 that the SDC had taken care of the orders and faxed them to the pharmacy and they had waited for the delivery that would arrive between 2:00 AM and 4:00 AM on 10/28/17. The DON stated that if the pharmacy received new orders after 4:00 PM they would not fill the medication until the next day. She added that if it was an IV medication then someone from the facility should have contact the pharmacy and requested an extra delivery so the medication could have been initiated as ordered. The DON confirmed that she had not contacted the pharmacy to request the IV medication be delivered sooner and was not aware that Resident #2 had missed 8 doses on admission to the facility.	F 760		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and physician interview the facility failed to obtain laboratory test as ordered for a resident receiving intravenous (IV) antibiotics for 1 of 3 residents sampled for laboratory services (Resident #2). The findings included: Resident #2 admitted to the facility on 10/27/17	F 770	F770 The plan of correcting the specific deficiency The position of Magnolia Lane Nursing and Rehabilitation center regarding the process that lead to this deficiency-failure to obtain laboratory test as ordered for a	1/12/18

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F 770	Continued From page 23 and discharged from the facility on 11/27/17. Resident #2's diagnoses included: aortic valve endocarditis (inflammation of the heart valve), acute pulmonary disease, and others. Review of the most recent comprehensive minimum data set (MDS) dated 11/03/17 revealed that Resident #2 was cognitively intact and required limited assistance with activities of daily living. The MDS further revealed that Resident #2 received intravenous (IV) medications during the reference period. Review of a facility document titled "Final Report: Outpatient Antimicrobial Therapy Orders" (OATO) dated 10/27/17 which accompanied Resident #2 to the facility. The OATO order sheet indicated that the Physician supervising the IV antibiotic therapy was Physician #1 and Resident #2 was to receive intravenous (IV) antibiotics and required a basic metabolic panel (BMP), complete blood count (CBC), and a liver function test (LFT) weekly on Mondays and was to be faxed to Physician #1's office within 24 hours. Review of Resident #2's medical record revealed the following laboratory test: 10/30/17 (Monday): BMP, CBC, and LFT were drawn as ordered. 11/06/17 (Monday): None of the ordered laboratory test were drawn. However on Friday 11/10/17 a CBC was drawn. 11/13/17 (Monday): None of the ordered laboratory test were drawn. However on Wednesday 11/15/17 a CBC and BMP were drawn but no LFT was drawn.	F 770	resident receiving intravenous antibiotics- was staff failure to follow policies for receipt of physician orders, and diagnostic services for laboratory testing related to knowledge deficit. Resident #2 was discharged to the community on 11/27/17 with home health and follow-up with physician on outpatient basis. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 1/11/18 the facility consultant audited residents with intravenous antibiotic (IV) orders for 12/9/17 through 1/10/18 to ensure all laboratory orders were completed as ordered with no negative findings. On 1/11/18 the facility consultant audited residents admitted from 12/11/17 through 1/11/18 to ensure admission laboratory physician orders were completed as ordered with no negative findings. On 1/10/18 the facility consultant in-serviced the director of nursing, staff facilitator, and the minimum data set nurse on policies for receipt of physician orders, and diagnostic services related to laboratory testing to ensure laboratory orders are transcribed, and completed per physician order including reviewing the discharge summary for physician ordered laboratory tests, including residents on IV antibiotics. All licensed nurses will be in-serviced by 1/12/18, including agency and new hires by the director of nursing, staff facilitator,	

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F 770

Continued From page 24

11/20/17 (Monday): None of the ordered laboratory test were drawn.

11/27/17 (Monday): None of the ordered laboratory test were drawn.

An interview was conducted with the Staff Development Coordinator (SDC) on 12/14/17 at 11:08 AM. The SDC confirmed that she transcribed Resident #2's order upon admission. She explained that it was collaborative effort of the nursing department to complete the admission process, no one was assigned to any individual task, it was just who ever could get to it would complete the process. The SDC stated that as far as the laboratory test those could not be entered into the lab system because all of the billing information had not been entered. The SDC explained that Resident #2 admitted on a Friday and the admission process was not completed before the billing office left for the weekend so we could not enter any labs into the system until that portion of the process was complete. She added that once the admission process was completed and the billing information had been entered then someone from nursing should have gone into the lab system and scheduled the ordered laboratory test to be drawn weekly on Mondays as stated in the OATO.

An interview was conducted with Physician #1 on 12/14/17 at 3:54 PM. Physician #1 stated that Resident #2 was being treated for endocarditis and required 6 week course of IV antibiotics. In addition Resident #2 required weekly blood test to monitor the effectiveness of the IV antibiotics. Physician #1 stated that getting laboratory test for Resident #2 was very difficult and the last

F 770

or minimum data set nurse on policies for receipt of physician orders, and diagnostic services related to laboratory testing to ensure laboratory orders are transcribed, and completed per order including reviewing the discharge summary for physician ordered laboratory tests, including residents on IV antibiotics.
The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements

The director of nursing, staff facilitator, facility consultant, and/or minimum data set nurse will audit 100% of residents on IV antibiotics weekly for 4 weeks then 50% of residents on IV antibiotics per week for 8 weeks to ensure laboratory testing was completed as ordered. This audit will be documented on the Quality Improvement Action Team Laboratory Monitoring tool.
The director of nursing, staff facilitator, facility consultant, and/or minimum data set nurse will audit 100% of residents admitted in the previous 7 days weekly for 4 weeks then 50% of residents admitted in the previous 7 days weekly per week for 8 weeks to ensure laboratory testing was completed as ordered. This audit will be documented on the Laboratory Monitoring audit tool

The monthly QI committee will review the results of the medication audit tool monthly for 3 months for identification of trends, actions taken, and to determine

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F 770	Continued From page 25 laboratory test he received was on 11/09/17. He added that he would have wanted at least 2 more sets of the laboratory test that were ordered so that he could have been comfortable that the antibiotics were not adversely effecting Resident #2. He added that the ordered laboratory test were clearly outlined and communicated with the facility and he would have certainly expected the laboratory test to be drawn and faxed to his office. An interview was conducted with the Director of Nursing (DON) on 12/15/17 at 1:50 PM. The DON stated that whichever nurse accepted the patient could enter orders into the laboratory system. She added that once the resident was entered into the system anyone from the administrative team could enter orders into the laboratory system. She stated she expected laboratory test to be drawn as ordered and faxed as instructed per the OATO orders. The DON stated that a lot of times she would enter orders into the laboratory system but could not recall if she had entered the order for CBC, BMP, and LFT or not but stated if they were not drawn then more than likely they were not entered correctly into the system. She further stated that once orders were entered into the laboratory system the technician from the contracted company would come in and draw them based on the orders that the facility had inputted.	F 770	the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Director of nursing is responsible for implementing the acceptable plan of correction.	
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State	F 865		1/12/18

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F 865	Continued From page 26 Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(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. §483.75(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, record reviews, and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor those interventions that the committee put into place in October 2017 following a recertification and complaint survey and subsequently recited in December 2017 on the current complaint survey. The repeat deficiencies are in the areas of care plan implementation (F656) and sufficient nursing staff (F725). These deficiencies were recited during the facility's current complaint survey. The continued failure of the facility during 2 federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referred to: 1a). 438.20 Resident Assessment: Based on observations, record reviews, family, and staff	F 865	F 865 QAPI Committee The plan of correcting the specific deficiency The position of Magnolia Health and Rehabilitation center regarding the process that lead to this deficiency-failed to maintain implemented procedures and monitor those interventions that the committee put into place- was failure to follow established facility policy related to QAPI. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 1/10/18 the facility QAA Committee held a meeting to review the purpose and function of the QAA committee and review on-going compliance issues. The	

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F 865 Continued From page 27

interviews the facility failed to implement care plan interventions by not applying protective geri sleeves (Resident #16) for 1 of 3 residents sampled for care plans.

During the recertification and complaint survey of 09/08/17, this regulation was cited for failure to follow the care plan for the number of desired showers per week for 2 of 7 residents reviewed for choices (Resident #35 and #7).

During the complaint survey of 12/15/17, this regulation was cited for failure to apply geri sleeves as directed by the care plan.

1b). 438.35 Nursing Services: Based on observations, record reviews, family and staff interviews the facility failed to provide nursing staff of sufficient quantity to provide showers and oral care. This affected 2 out of 5 residents (Resident #1 and Resident #9).

During the recertification and complaint survey of 09/08/17, this regulation was cited for failure to provide enough staff to provide showers as scheduled for 3 residents (#20, #59, and #78), provide treatment for skin tear for 1 resident (#41), and provide medications in a timely manner (Resident #21 and #15).

During the complaint survey of 12/15/17, this regulation was cited for failure to have sufficient quantity of staff to provide showers and oral care.

An interview was conducted with the Administrator on 12/15/17 at 4:11 PM. The Administrator stated that she had only been at the facility for a few days and was not very familiar with the facility ' s Quality Assurance (QA)

F 865

Administrator, DON, MDS nurse, staff facilitator, maintenance director, and housekeeping supervisor will attend QAPI Committee Meetings on an ongoing basis and will assign additional team members as appropriate.

On 1/10/18 the corporate facility consultant in-serviced the facility administrator, director of nursing, admissions, activities director, maintenance director, dietary manager, therapy director, medical records, social worker, payroll, minimum data set nurse, and staff facilitator related to the appropriate functioning of the QAPI Committee and the purpose of the committee to include identify issues and correct repeat deficiencies related to F656- care plan implementation, and F725- sufficient staffing.

As of 1/10/18 after the facility consultant in-service, the facility QAPI Committee will begin identifying other areas of quality concern through the QI review process, for example: review of rounds tools, review of work orders, review of Point Click Care (Electronic Medical Record), review of resident council minutes, review of resident concern logs, review of pharmacy reports, and review of regional facility consultant recommendations.

The Facility QAPI Committee will meet at a minimum of monthly and Executive QAPI committee meeting a minimum of quarterly to identify issues related to quality assessment and assurance

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F 865	Continued From page 28 practices. She stated that she had already identified that staffing was an issue at the facility. She went on to say that just recently they approved a 2nd staffing agency and they had talked about sending the certified geriatric assistants (CGAs) to school to become Nursing Assistants (NAs). The Administrator added that she was meeting with a website company in the near future so they could teach her how to list advertisements on the internet to recruit new employees. An interview was conducted with the Regional Vice President (RVP) of the company on 12/15/17 at 4:24 PM. The RVP stated that the QA committee met monthly or more often as needed and included all the department heads at the facility. He added that the quarterly QA meeting involved the medical director, pharmacist, all department heads, Administrator, and Director of Nursing (DON). The RVP stated that they were still conducting and reviewing audits from the last recertification and complaint survey. He added that the DON was conducting the audits and sending them to the facility ' s nursing consultants for input. He also added that the QA meeting was scheduled for next Friday and they planned to discuss the current audits and the results of the most recent complaint survey. The RVP stated that he felt like they had enough staff to meet the needs of the current residents because their acuity level was not high. He added that when the staff tell him that they need help he explained to them that we could contact the agency and we have offered incentives to work extra shifts including sign on bonus. The RVP went on to say that the facility was in a "staffing crisis" because they had to terminate some employees and the facility scheduler worked day to day to cover the	F 865	activities as needed and will develop and implementing appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to F656- care plan implementation, and F725- sufficient staffing. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The executive QAPI committee will continue to meet at a minimum of Quarterly, and QAPI committee monthly with oversight by a corporate staff member. The Executive QAPI Committee, including the Medical Director, will review quarterly compiled QAPI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QAPI 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 title of the person responsible for implementing the acceptable plan of	

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F 865	Continued From page 29 building. He further stated that he was aware of the staffing issue and had been working on it and would continue to do so.	F 865	correction The administrator is responsible for implementation of the acceptable plan of correction.	