PRINTED: 09/01/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345288	B. WING _	B. WING		C 7/21/2017	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	72 1720 17	
	A FOTATEO OKU I ED OA			1404 S SALISBURY AVENUE			
MAGNOLI	A ESTATES SKILLED CA	ARE		SPENCER, NC 28159			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS		FC	00			
	Immediate Jeopardy	(IJ)-Removed:					
	A recertification and conducted from 7/16/ Immediate Jeopardy	17 through 7/21/17.					
	(J)	224 at a scope and severity					
	CFR 483.25 at tag F323 at a scope and severity (J) CFR 483.75 at tag F490 at a scope and severity (J) The tags F224 and F323 constituted Substandard Quality of Care.						
		began on 04/19/17 and was An extended survey was					
F 157 SS=G	483.10(g)(14) NOTIF (INJURY/DECLINE/R		F1	57		8/11/17	
	(g)(14) Notification of	Changes.					
	consult with the reside	ediately inform the resident; ent's physician; and notify, her authority, the resident en there is-					
		ring the resident which as the potential for requiring n;					
	mental, or psychosoc deterioration in health	ge in the resident's physical, ial status (that is, a n, mental, or psychosocial reatening conditions or					
A DODATODY I	DIDECTOR'S OR DROVINER/S	SLIPPLIER REPRESENTATIVE'S SIGNATURE	I .	TITI F		(X6) DATE	

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

Electronically Signed

08/09/2017

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	COMPLETED	
		345288	B. WING		C 07/21/2017
NAME OF PROVIDER OR SUPPLIER MAGNOLIA ESTATES SKILLED CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 157	a need to discontinu treatment due to addicommence a new for (D) A decision to train resident from the fat §483.15(c)(1)(ii). (ii) When making not (14)(i) of this section all pertinent informatis available and prosphysician. (iii) The facility must resident and the resident a	reatment significantly (that is, the an existing form of everse consequences, or to form of treatment); or the instance of the cility as specified in the cility as specified in the facility must ensure that the specified in \$483.15(c)(2) (vided upon request to the ident representative, if any, in or roommate assignment assignment as specified in paragraph	F 15		
	by: Based on observati interviews and record notify the physician urinary catheter inse	ons, staff and physician rd review, the facility failed to for a change in condition of a certion site (urethra) for 1 residents reviewed for urinary ags included:		Resident #20 s physician was notifit the change of condition to the residence penis on 8/7/17. There are no other residents in the fawith a urinary catheter. The Nurse Aides will be in-serviced of	nt⊟s acility

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	ROVIDER OR SUPPLIER	ARE		STREET ADDRESS, CITY, STATE, ZIP CO 1404 S SALISBURY AVENUE SPENCER, NC 28159	DDE	0172172011
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 157	cumulative diagnose Cerebrovascular Dishistory of urinary trace. A review of Resident admission dated 11/2 concern to his urethrough A review of Resident assessment dated 0-showered and no skino mention of any arresponding to the facility on 5/21. A review of his re-add dated 5/21/17 read review of a PA progression of antibiotics thick milky looking urread he had an indw large amount of sediurine was described mention of staff concepnis. A review of Resident dated 6/8/17 indicated Mental Status (BIMS)	dmitted on 11/22/16 with s of Parkinson's Disease, ease, urinary retention, and of infections. #20's skin assessment on 23/16 read no areas of a. #20's weekly skin 4/24/17 read his had been in issues noted. There was eas of concern to Resident in a. #5/16/17 at 10:44 PM read ent to the hospital and uria and a UTI. He returned	F 1	urinary catheter care by the Nurses and Regional Nurse 8/11/17 to include retracting needed, clean the penis, cle urethra, and clean the cathete bottom holding and not putti the catheter. Rinse, dry gen catheter with leg strap. Hang catheter bag appropriately a charge nurse of any change. The nurses will be educated Director of Nurses and Regi Consultant by 8/11/17 on do of change of condition with rephysician and responsible por The 24 hour nursing report or reviewed daily by the Director Nurses/Unit Manager for all condition and will be reviewed morning clinical meeting with administrator for physician are responsible party notification. The Director of Nurses will the and concerns related to phy responsible party notification monthly Quality Assurance of monthly for 3 months.	Consultant by the foreskin if the ten the other from top to ong tension on the tension on the tension on the tension of the te	

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F 157	activities of daily living having a urinary cath Assessment for his ureader to his care plate A review of Resident 6/8/17 read the follow *Resident #20 had a urinary retention and #20 had a history of attempts to stand or assistance with his demptying. He had a linterventions include *Observation of Resirritation and redness *Ongoing assessmentis urine *Assessment of Resident #20 *Provide catheter ca *Change his cathete *Obtain Urinalysis a *Ensure the catheter A nursing note dated Resident #20 removing at his beds replaced without diffid documented evidence of his urethra or that physician.	assistance with all his ag (ADLs) and coded as neter. The Care Area urinary catheter referred an. ##20 's care plan dated wing problem: urinary catheter due to a prostate cancer. Resident of stretching his tubing in move about. He needed staff atheter care and urinary bag history of frequent UTI 's. ##20 's skin daily for stretching his tubing in move about. He needed staff atheter care and urinary bag history of frequent UTI 's. ##20 's skin daily for stretching his tubing in move about. He needed staff atheter care and urinary bag history of frequent UTI 's. ##20 's care plan dated staff at the cancer and urinary bag history of about. He needed staff at the color and clarity of a dent for sign of a UTI perineal care as needed to a Urologist as needed as ordered and as needed are as ordered and as needed at tubing is secured to his thigh a december of the urinary catheter and it side. The urinary catheter and it side. The urinary catheter was culty. There was no be of trauma of assessment it was reported to the	F 15	57		
	physician. In an observation an 10:23 AM, Nursing A	•				

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345288 B. WING C 07/21/	1/2017
NAME OF PROVIDER OR SUPPLIER MAGNOLIA ESTATES SKILLED CARE STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 Continued From page 4 pulled back Resident #20 's sheet. There was no observed anchoring device to either thigh. She stated she was not aware that his urinary catheter should be anchored to his thigh. She stated she was instructed to make sure his urinary bag was attached to his bed but not aware that his urinary bag should not be lying on the floor. NA #13 stated in the past when she was assigned Resident #20 she was only instructed to empty his urinary bag. She was not aware of how to perform his urinary catheter care or what to report to the nurse. In an interview on 07/18/17 at 10:38 AM, Nurse #2 stated she had observed blood in in his urine on occasion. Nurse #2 stated the aides clean his catheter and she assessed his catheter daily to ensure there were no concerns. Nurse #2 stated the aides had not told her that his catheter was not anchored and not told her about any observed concerns to his penis or urethra. Nurse #2 stated if the aides reported or she observed any changes in the appearance of Resident #20 's urethra, it should be reported to the physician. In an interview on 07/18/17 at 3:30 PM, Nurse #1 stated she started in January of 2017 and was assigned Resident #20 on 7/17/17 and thought he did not have a leg strap because it irritated his leg. She stated she did not assess his catheter insertion site or penis but expected the aides to report anything unusual to her. Nurse #1 stated if the aides reported or she observed any changes in the appearance of Resident #20 's urethra, it should be reported to the physician.	

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F 157	9:30 AM, NA #2 state facility for one year at Resident #20. During #20 's catheter care, urethra and cleaning attempt to clean the ewas asked to further back his testicles and penile tear extending underside of the shaf approximately 2 inchepenis was not like that November 2016 and nurse. In an interview on 07, confirmed she looked daily. She stated she on his admission but today. Nurse #2 state monthly on night shift have been reported to observed during his consistency in an interview on 07, #3 stated she worked thought Resident #20, "awhile". She describ "ridge" on his penis be penis in probably a murse who worked nigurinary catheter. She catheter was documenight nurse on 7/17/1	d interview on 07/19/17 at d she had worked at the and she was assigned an observation of Resident she cleaned around his his tubing. She did not entirety of his penis. NA #2 reveal his penis by pushing foreskin. Observed was a from the urethra down the tof his penis measuring as in length. NA #2 stated his at when he was admitted in it should be reported to the should be reported to the should he had a small tear it did not look like it did and the penile tear should to his physician when it was eatheter change. 19/17 at 10:50 AM, Nurse #2 third shift. She stated she had a small tear for ed it as a 2 centimeter ut she had not observed his conth. She stated the other ghts usually changed his confirmed Resident #20's ented changed by the other	F	157		
	Nurse #6 confirmed s	the worked nights and 7/17/17. She stated she had				

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F 157	past but not recently she documented on urinary catheter More #6 stated she did no 07/17/17 as docume an explanation as to TAR that she change catheter when on intended the penile tear at ear to Resident #2 been reported to his A review of the facility 4:00 PM from Nover included no intakes at change in Resident at his urethra. In an interview on 7/ stated it was her first assignment after a 3 hall. The Director of were observed asse The DON pulled back and testicles to revestated "it wasn't like stated he may have maybe a little split be now. The DON stated it had worsened since weeks ago". She stated that it would have be	20 's urinary catheter in the . Nurse #6 was reminded his TAR she changed his day night on 07/17/17. Nurse t change his catheter on nted. She was unable to offer why she initialed off on the ed Resident #20 's urinary erview, she stated she did thought she changed his onth or so ago and had ood at his urethra but had not . She stated if she observed 20 's urethra, it should have	F	157			

NAME OF PROVIDER OR SUPPLIER MAGNOLIA ESTATES SKILLED CARE B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1404 \$ SALISBURY AVENUE SPENCER, NC 28159	C 21/2017 (X5) COMPLETION DATE
NAME OF PROVIDER OR SUPPLIER MAGNOLIA ESTATES SKILLED CARE STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159	(X5) COMPLETION
OLIMANDY OTATEMENT OF REFIGIENCIES	COMPLETION
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 157 There were no nursing notes again until 7/19/17 at 4:59 PM which read Resident #20 's urinary catheter was changed without difficulty. In a telephone interview on 07/21/17 at 9:45 AM, Resident #20 's physician stated it was her expectation that she be notified of any changes such as trauma or tearing to Resident #20 's s penis or urethra. In an interview on 07/21/ at 10:40 AM, the Administrator stated her expectations were the same as Resident #20 's physician. F 224 483.12(b(1)-(3) PROHIBIT S-J \$483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(b) The facility must develop and implement written policies and procedures that: (b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (b)(2) Establish policies and procedures to investigate any such allegations, and (b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by:	8/18/17

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	L	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	72172011	
				1404 S SALISBURY AVENUE			
MAGNOLIA ESTATES SKILLED CARE			SPENCER, NC 28159				
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F 224	Continued From pag	e 8	F 22	4			
	Based on observation	ons, interview with facility		Resident #47 no longer resides	in the		
		Administrator and records		facility.			
	review the facility fail	ed to prevent an avoidable					
	fall from mechanical	lift resulting in injury for 1 of		All other residents as having the	potential		
	6 residents reviewed	for accidents and falls		to be affected by the use of the			
	[Resident # 47].			mechanical lift had their transfer			
				re-assessed by the DON and M			
	I .	# 47 who was severely		coordinator on 7/18/17 for the n	eed for the		
		ad a fall with injuries while		mechanical lift.			
		echanical lift, with only one		Care plane and save suides was			
	person assist. The resident's care plan and facility policy indicated two (2) person assist for			Care plans and care guides wer			
		a lift. Resident # 47 had a		by the MDS coordinator to indic person assist and transfer for the			
		d, C1 Jefferson fracture and		requiring the mechanical lift.			
	I .	ture due to the fall. Resident		requiring the inconamear int.			
	# 47 expired on 5/13			On 4/20/17 and 4/21/17 the nur	se aides		
				were re-educated on the use of			
	Immediate Jeopardy	began on 4/19/17 at 2:30		mechanical lift and skills observ			
		four straps were not all		completed by the Rehab Directo	or.		
	unhooked before the	sling was removed from the					
	resident. This cause	d the resident to be pulled		The nurse aides will be trained l	by the		
	into the floor. The in	nmediate jeopardy was		therapy department on the use	of the		
		at 12:30 PM when the		lifting device upon hire and annu			
	facility's acceptable of			show continued competency on	the lifting		
	·	fied. The facility will remain		device.			
	T	a scope and severity level D			n e		
	1	potential for more than		The direct care staff to include f			
		not immediate jeopardy) to		and part time staff was re-educa	ated by the		
		for therapy or licensed nurse ts for determination of the		administrator on 7/18/17 on the importance of reviewing the care	e guide		
	safest mechanical life			daily for updates and to underst	-		
	assessment evaluati	•		expected outcome of the reside			
		pleted by the rehab director,		Staff will not be permitted to wo			
	resident's care plan			in-service's are complete. Care			
	, and the same plant	ga.ac.		each resident are located on the	•		
	Findings included:			their closet door.			
	Resident was admitte	ed to the facility on 7/25/12		Upon hire the direct care staff w	rill be		
	and on readmit date	on 5/7/14, with documented		educated on care guides, its pu	rpose and		

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			A. BOILDI	NG _		Ι,	С
		345288	B. WING				21/2017
NAME OF PRO	VIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0	
				14	404 S SALISBURY AVENUE		
MAGNOLIA	ESTATES SKILLED CA	ARE		S	PENCER, NC 28159		
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	alls, Dysphagia, Othe current pathological find abnormalities with pateoarthritis. Review of the Quarte MDS) dated 4/10/17 5/7/14. Resident was unclear speech and resident and needing and properties with dressing, or any giene. Resident was mpairment for both simple medication. Resident mechanical altered, the Review of the care play problem area with one otal assist with Activities and requires staff to pay will minimize potential and requires staff to pay will minimize potential at two (2) assist transforms to wear orthotic and incomplete and mechanical lift, the lift weights.	reimer's Dementia, history of er osteoporosis without racture, lack of coordination, h gait and poly rly Minimum Data Set revealed admission date coded as minimum hearing, arely /never make dent was severely Resident was coded as total ing two person assist with and bathing, one person eating, toileting and personal is having functional limitation ides of lower extremity. In twas not on any pain was coded as being on inerapeutic diet. an dated 4/18/17 revealed set date 1/13/17- "Requires ties of Daily living (ADL). Sis of Alzheimer's dementia, gets up to a care foam chair propel. The goal stated that all for significant decline in ventions stated resident was fer with the total lift. Geri ms as orders and resident hip abduction braces as	F	224	their location. On 7/19/17 in-services began for all st to include full time and part time staff in departments and they were re-educate on the facility sabuse/neglect policy the administrator and Director of Nurse and the education included to follow the care plan and care guide for each individual resident and was completed 7/24/17. A 24 hour initial report was completed the administrator and sent to North Carolina Division of Health and Human Service/Health Care Personnel Investigation on 7/20/17. A 5 day report was completed 7/26/17 sent to North Carolina Division of Heal and Human Service/Health Care Personnel Investigation by the administrator (HCPI). The HCPI has a scheduled visit for 8/9 for their investigation. Upon any reports of abuse/neglect the administrator/DON will report any allegations to HCPI within the 2 hour/2 hour time frame. Any reportable allegations will be reviewed by the V.P. of Operations/Regional Nurse Consultant and in addition the reports will be reviewed in monthly Quality Assurance (QA) Committee for 3 months and the quarterly Executive QA Committee for continued quality improvement.	n all ed by es's e on by 1 and th /17	

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F 224	Continued From pag		F 22	24		
	three (3) loops not al was pulled to the floo the roommate's bed Resident was sent to	esident on bed, NA undid I four (4) from lift. Resident or and bumped her head to rail when the lift was moved. Emergency Room (ER) for ation. Nurse Practitioner (NP) y was notified.				
	in part - NA #9 was v putting the resident of four (4) from lift. Wh resident was pulled t roommate's bed rail. top of head due to ar	nt report dated 4/19/17 read veighing resident when on bed undid (3) loops not all en NA moved the lift, o floor and bumped head on Resident has laceration to mount of blood could not rly. Pressure applied to the				
	report 4/19/17 at 2:26 floor lying supine. No being transferred from hit head. Neck pain the bed 3 feet (ft). Neck	by Medical Services (EMS) 8 PM read in part: Patient on a lirse reported resident was my wheelchair to bed, fell and o palpation due to fall from pain on palpation and tender a limmobilized to hospital.				
	read in part: Patient fell, sustained a lace Diagnosis: posterior cervical vertebra (typ non-displaced fractul and possible compresent Hospital admission in PM read in part - Resented in part - Resented in part - Resented in the part in the part in part in the part in part in the part in part	dated 4/19/17 at 3: 05 PM in ER, lift broke and patient ration on top of scalp. displacement of second re 2 odontoid fracture) and re of first cervical vertebra, resion of upper cervical cord. ote dated 4/19/17 at 10:18 resident was admitted to pital admission note indicate referred from Hospital via ical vertebra (C1) Fracture.				

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F 224	home after sustaining Unknown if there was (LOC). She fell from so of impact was the head only incomprehensible follow command. Per mental status. She has her head. Point of im Review of ED Provide 10:46 PM read in par hours ago. Fall occur Facility (SNF) from Meight of 3 to 5 ft. and neck. Clinical impress fracture of first cervice fracture morphology. Review of Orthopedic 10:48 PM read in par outside hospital where first cervical vertebra vertebra fracture. As Recommendation incommand C2 type 2 odonto (MJ) cervical collar at (HOB) as tolerated; to fineurological compassociated with surgismorbidity. Recommensurgical intervention. Review of Employee Statement dated 4/20 utilize two staff for us	ospital from her nursing a fall from a mechanical lift. It is loss of consciousness a height of 3 to 5 ft and point ad and neck. Patient makes be sounds and was unable to EMS was her normal as a laceration to the top of pact head and neck. The receiver the tensor of pact head and neck. The receiver the tensor of pact head and neck. The receiver the tensor of pact head and neck. The receiver the tensor of pact head and neck. The receiver the tensor of pact head and neck. The receiver the tensor of pact head and soin - Closed displaced all vertebra, unspecified The Note dated 4/19/17 at the patient was seen at an and the seen at an and the seen at an and the seen and the sees of the tensor of pact head of bed his injury does not have risk romise, however risk all times; head of bed his injury does not have high and no acute orthopedic The revealed NA #9 failed to be of Mechanical lift for Corrective actions were 1) inical lift. 2) Return	F2	224		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LE CONSTRUCTION G	COM	(X3) DATE SURVEY COMPLETED		
		345288	B. WING		C 07/21/2017		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159	1 07	21/2017	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 224	Continued From paç	ge 12	F 22	4			
	4/21/17 read in part (BP) remained eleva Hemodynamically s	cal Discharge Summary dated - Resident blood pressure ated despite home regime. table at discharge and at rus. Recommended maintain					
	part: Resident arrive transport at 7:17 PM neck. Resident stab signs taken. Reside some bruising noted right lower arm at IV unlabored. Incontin	ote dated 4/21/17 read in ed to facility via facility 1, MJ collar in place on the le, alert, nonverbal. Vital nt skin dry and intact with to back of both hands and site, respiration even and ent of Bowel and Bladder, no l, will continue to monitor.					
	7:05 AM, nurse indice residents weights the stated NA #9 came her about Resident be before or after lu #47 was examined I transported her to the Nurse #2 further state required when using unsure why NA #9 v	with Nurse #2 on 7/18/17 at cated NA #9 was assigned e day of the incident. Nurse running to her and informed #47 fall, unsure of time (may nch). Nurse stated Resident by EMS upon arrival and he hospital in a stretcher. Ited that two (2) people were to the mechanical lift and was was working alone with the weighing the residents.					
	11:38 AM, NA indica weights for the resic day of the incident, lift to weigh Resider resident was placed up to be weighed. A	with the NA #9 on 7/18/17 at atted she was usually assigned lents. She indicated on the she was using a mechanical at # 47. NA #9 stated the on the pad and hooked, lifted fter the weight was taken the d down on the bed. NA #9					

AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345288	B. WING		07/21/2017
	ROVIDER OR SUPPLIER	ARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159	0772172017
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 224	stated she had unhouslips and when the member walked in, stated she responder left, NA stated she the of the four (4) hooks back. NA #9 stated as he could not reach fallen down. She state the nurse for assess working alone with the staff should facility did not ask for assist usually works alone lift as she was assig time. NA #9 indicate if the resident was observed. During an interview of 07/21/2017 at 10:41 the staff should follow using two (2) personneglect. On 7/18/17 at 2:30 A corporate nurse compresident were information. The Administrator proceedible allegation of Allegation of Compliation	esident's roommate family she was distracted. She d'patient care" and after he hought she had removed all from the pad and moved at this point she felt a tug and the resident as resident was ted she immediately called ments. NA #9 stated she was ne Mechanical lift that day. If had other NA, but she just tance. She also stated she with weights and Mechanical ned to that duty for a long d that she only asks for help ombative or a heavy weight. With the administrator on AM, Administrator indicated we the care plan and by not for Mechanical lift it was a sultant, corporate vice med of immediate jeopardy. Ovided an acceptable of compliance on 7/21/17.	F 22	4	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345288	B. WING			C 07/21/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 1404 S SALISBURY AVENUE SPENCER, NC 28159		7/21/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 224	unhooking 3 of the 4 room and the c.n.a. sethe visitor left the room the resident she was started to pull the me. The c.n.a. had forgot the fourth hook and the roll and fell from the distracted by the visit causing her not to un c.n.a. did not have a the mechanical lift be not transferring the recommon practice for resident. The conclusion of the policy the c.n.a. woul while using the mechanical the facility. The second told the first c.n.a. the attached prior to move could have prevented. On 4/19/17 at 2:15 Presidents weight the diff without unhooking resident to fall from the obtained a laceration. The physician and far at 2:30 PM and the referency room for observation and returns.	the pad onto the lift. After hooks a visitor entered the stated out "resident care" and m. The c.n.a. turned back to weighing and at this point schanical back from the bed. Iten that she had not undone the resident had started to bed. The c.n.a. was for coming into the room do the fourth hook. The second person to assist with scause she stated she was esident and this was her obtaining weight for this erroot cause, if following the do have had a second staff sanical lift per the policy of a staff member could have at the fourth hook was still ring the mechanical lift and	F 22	24			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		345288	B. WING _		07/21/2017		
	ROVIDER OR SUPPLIER A ESTATES SKILLED CA	ARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159	<u> </u>	5772172017	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 224	by the Rehab Director of using a Hoyer lift of Using a Hoyer lift of On 4/20/17 and 4/21/17 re-educated on the usure observations completed. Other residents idented to be affected by the transfer status was remarked to indicate the carrier of those requires and the carrier of those requires the transfer for those requires the transfer status of the transfer status of the reviewed quarterly with as needed. The Reham the carrier of the transfer status of th	r lift while weighing a viced on use of the Hoyer lift or, with return demonstration in 4/20/17. 17 the CNAs were se of the Hoyer lift and skills ted by the Rehab director. Iffed as having the potential use of mechanical lifts, eassessed by the DON and 17/18/17 for the need for the e plans and care guides cate 2 person assist and uiring a Hoyer lift.	F 2	24			
	Plan and Care Guide convey changes to the meeting and the charmour report for the foll after daily morning clishifts will then common c.n.a.'s for their indivinurse will monitor the care guides are follow care provided accord reported to the DON possible neglect. The Certified Nursing the therapy department.	Assistant will be trained by ent on the use of the lifting d annually to show continued					

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		345288	B. WING		C 07/24/2047	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159	I	07/21/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 224	be affected for use of identified on their car re-educated on the upolicy on 4/20/17 and Director. A 24 hour initial report and sent to N.C. Divis Services/Health Care the administrator. The direct care staff of by the administrator or reviewing the care guanderstand the experiesidents care. Care located on the inside On 7/19/17 in-service departments and wer facility's abuse/negle and DON and the edithe care plan and car resident to be complete.	esidents with the potential to a mechanical lift have been e plans. All staff were se of the mechanical lift 14/21/17 by the Rehab that was completed on 7/20/17 sion of Health and Human Personnel Investigations by was re-educated on 7/18/17 on the importance of ide daily for updates and to cted outcome of the guides for each resident are of their closet door. The segan for all staff in all the re-educated on the ct policy by the Administrator ucation included following the guide for each individual sted by 7/24/17. The segan for 7/21/17	F 2	224		
F 241 SS=D	confirmed they had re the use of mechanica reviewing of care guid facilities abuse and n remain out of complia severity. 483.10(a)(1) DIGNIT	des and also re-educated on eglect policy. The facility will ince at a lesser scope and	F 2	41		8/18/17

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345288	B. WING			C 07/21/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	0772172017	
MAGNOLI	A ESTATES SKILLED CA	ARE		1404 S SALISBURY AVENUE SPENCER, NC 28159			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	<u> </u>		(X5)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	O THE APPROPRIA		
F 241	Continued From page	: 17	F 2	241			
Γ 241	(a)(1) A facility must to resident in a manner promotes maintenancher quality of life reconstruction individuality. The facility of the resident manner promote the rights of This REQUIREMENT by: Based on observation interviews the facility dining experience for 71 and Resident #9) their meals at the same residents in 1 of 2 din observations. The fact residents (Resident #461 and Resident #461 and Resident #461 iquids and supplement beverages out of during residents were observed in the year package. Findings Included: 1. During a dining observed in the dining residents were observed in the dining residents were observed in the dining room at meal. At 6:05 pm and the nursing unit and a received her meal trains in the dining room at meal. At 6:05 pm and the nursing unit and a received her meal trains in the dining room at meal and the nursing unit and a received her meal trains in the dining room at meal and the nursing unit and a received her meal trains in the dining room at meal and the nursing unit and a received her meal trains in the dining room at meal and the nursing unit and a received her meal trains in the dining room at meal and the nursing unit and a received her meal trains in the dining room at meal and the nursing unit and a received her meal trains in the dining room at meal and the nursing unit and a received her meal trains in the dining room at meal and the nursing unit an	reat and care for each and in an environment that the or enhancement of his or gnizing each resident's ity must protect and the resident. It is not met as evidenced and the resident and the resident. It is not met as evidenced and the resident		Resident #71 has been main dining room for me Resident #9 will remain i dining room. The Dietary, Activity and in-serviced by the Regist 8/14/17 on dignity and dinclude all drinks and supeing served in the approup and not in the packa Also included in the in-seresidents will be served at table and also both residents and also both residents ongoing basis in weekly Dietary Manager will control observations of residents the same time at the same include dining with dignit supplements served in a drinking cups. The dining be completed 2 times as a side of the same time at the sa	in the assisted I Nursing staff value of Dietician ining service to pplement drinking aged container. The ervice was all at the same at dents in a room wed on an PAR meeting. Implete dining as being served me table to to ty, all drinks an appropriate ag observation were desired.	on s g a a	
		vation on 7/19/17 at 12:45		then weekly for 1 month, months.		,	
	pm of the assistive di	ning room there were 4 g room that were being		All issues identified will b	oe brought to th	ne	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED C 07/21/2017	
		345288	345288 B. WING		0.		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		112112011	
WAGNUL	IA ESTATES SKILLED	CARE		SPENCER, NC 28159			
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F 241	12:45 pm until 1:1 she wheeled herse and the staff remointo the hallway. For continue to wheel multiple times and into the hallway. An interview with the assisting a resider assistive dining roweled the staff residents into the had been delivere #71's meal tray of stated Resident # set-up and should main dining room. An interview on 7/Dietary Manager (on getting the resident the correct order is served on the right at the same time. An interview on 7/Administrator reveall residents were	meals. An observation from 0 pm of Resident #71 revealed elf into the assistive dining room wed her from the dining room Resident #71 was observed to herself back in the dining room the staff kept taking her back. The Speech Therapist, who was not with their meal in the om, on 7/19/17 at 1:00 pm were told yesterday not to let dining room until their meal tray downward. The ST explained Resident came out on a later cart. She resident with tray be scheduled to eat in the conductor of the dining room until their meal tray downward. The ST explained Resident came out on a later cart. She resident with tray be scheduled to eat in the conductor of the dining room until their meal tray downward. The scheduled to eat in the resident is trays were to cart and they could be served to the saled it was her expectation that served their meals at the same dents were not just sitting there	F 2		ietary affected was etary Manager room nade per nges will be (PAR) meeting		
	5:48 pm Resident dining room. His n (oz.) containers of have a glass or a	#33 was eating in the assistive heal tray contained 2 - 4 ounce nectar thick tea. He did not straw to drink the beverages served drinking directly from the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345288 B. W			C 07/21/2017
	ROVIDER OR SUPPLIER	ARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159	1 01/2011
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETION
F 241	Continued From pag	ne 19	F 24	1	
	b) During a dining of 12:15 pm of the main was observed eating container of honey the container of honey the same container of honey the container of honey the same conta	oservation on 7/19/17 at an dining room Resident #19 and her lunch. She had 1 - 4 oz. nick tea and 1 - 4 oz. nick water. She did not have drink the beverages out of.			
	She was observed to	be drinking directly out of tainers that the thickened			
	pm of the assistive of observed eating her container of nectar the container of a health glass or a straw to d She was observed to tea directly out of the packaged in and dring	oservation on 7/19/17 at 1:00 lining room Resident #61 was lunch. She had 1 - 4 oz. hick tea and 1 - 4 oz. shake. She did not have a rink the beverages out of. to be drinking the thickened to 4 oz. plastic container it was hking the health shake oz. paper container it was			
	pm of the assistive of observed eating her container of nectar the container of a mighty glass or a straw to d She was observed to tea directly out of the packaged in and dring	oservation on 7/19/17 at 1:15 lining room Resident #40 was lunch. She had 1 - 4 oz. hick tea and 1 - 4 oz. y shake. She did not have a rink the beverages out of. to be drinking the thickened to 4 oz. plastic container it was hiking the mighty shake oz. paper container it was			
		/17 at 12:46 pm with Nursing vealed that not all residents			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED C	
		345288	345288 B. WING				
	ROVIDER OR SUPPLIER	ARE		STREET ADDRESS, CITY, STATE, ZIE 1404 S SALISBURY AVENUE SPENCER, NC 28159	07/21/2017		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 241	Continued From page	e 20	F 2	241			
	them out of. She state a red nosey cup to dr	eceived a glass to drink ed some residents received ink out of, but she didn ' t h cups for everyone to					
	Speech Therapist rev be good if all resident liquids also received a She stated that the pl liquid containers coul	17 at 1:18 pm with the realed she thought it would state that received thickened a glass to drink them out of. astic ridge of the thickened d be a little sharp. She on thickened liquids didn ' t					
	revealed he had not residents on thickene shakes did not have a stated it would be bet	17 at 11:45 am with the DM really thought about the d liquids or those receiving a glass to drink out of. He ter if they were provided with the on thickened liquids were liws.					
	the Administrator she home like for resident	n 7/21/17 at 11:26 am with stated it would be more ts to drink their thickened at of a glass and a glass					
		nted diagnosis of Stiffness of left knee, chemic attack, Dysphagia, geable heel and Dementia.					
		rly Minimum Data Set evealed admission date					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345288	B. WING			C 07/21/2017	
	ROVIDER OR SUPPLIER A ESTATES SKILLED CA		1	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159	1 077	21/2017
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE
F 241	impaired cognitive sk Mental Status (BIMS) coded as total dependence for bed mobility, transfer two personand toilet use 3/3. Resultant blader and bowel incoded as receiving moded at most mean at most mean soft diet with pureed at all meals. During lunch observation puring lunch observation moded as geriatric chair in the Resident #9 was observed any tray. During an interview was assisted with their modes as sisted with their modes are the served any tray. During an interview was served any tray was served any tray was served any tray was served. She stated the first serves meals to resid while the second cart later has trays for resultant as trays for resultant as trays for resultant as trays for resultant properties.	s coded as adequate ech, rarely makes dent was coded as severely ills with a Brief Interview for a score of 0. Resident was dence with two person assist afer, and personal hygiene. It assist with dressing, eating, esident was coded as always continence. Resident was echanically altered diet. It care plan dated 1/13/17 as: Potential for weight loss percent (%) or more food ls. Resident on mechanical meals and requires to be fed It come plan dated 1/13/17 as: Potential for weight loss percent (%) or more food ls. Resident on mechanical meals and requires to be fed It come plan dated 1/13/17 as: Potential for weight loss percent (%) or more food ls. Resident on mechanical meals and requires to be fed It come plan dated 1/13/17 as: Potential for weight loss percent (%) or more food ls. Resident we assisted dining hall. Between the weight loss percent (%) or more food ls. Resident #9 sitting in the easisted dining hall. Between the weight loss percent (%) or more food ls. Resident #9 was not lead to the percent with the second assistant and the second assistant are the second assistant are the second assistant are the second assistant are the second assistance, that arrives 15 - 20 minutes ident who need feeding slowly. She stated residents in ining hall according to their the further stated that as the stivities this morning the	F	241			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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	ROVIDER OR SUPPLIER A ESTATES SKILLED CA	ARE	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159	J 0//2//2011		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE		
F 241	Continued From page	e 22	F 241				
F 282 SS=G	a Nurse Aide (NA) an resident from the dini geriatric chair into the looked distressed wh hallway near the nurs alert and was unable. The second cart arriv #9 was observed been During an interview whom (DM) on 7/20/17 at 10 was working on the reso that that resident's right cart and served. During an interview who was not aware of resident meal time whom changes accordingly. 483.21(b)(3)(ii) SERV PERSONS/PER CAFT. (b)(3) Comprehensive The services provided as outlined by the commustance with each care. This REQUIREMENT by: Based on observation review, the facility fail	with the Dietary Manager 1:45 AM, DM indicated he esident's meal trays delivery is trays were served on the at the same time. with the administrator on Administrator indicated that if the situation and that the ould be revisited and VICES BY QUALIFIED RE PLAN e Care Plans d or arranged by the facility, imprehensive care plan,	F 282	Resident #20 had a urinary catheter the strap applied on 7/21/17. His catheter was repositioned to not touch the floor	bag		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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		345288	B. WING				21/2017
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MAGNOLI	A ESTATES SKILLED C	ARE		S	PENCER, NC 28159		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 282	Continued From page	e 23	F	282			
	prevent injury for 1 of	f (Resident #20) 1 reviewed			There are no other residents with a		
	for urinary catheters.				urinary catheter, therefore there are no		
	-	-			other potential residents affected.		
	Resident #20 was ad	Imitted on 11/22/16 with			Nursing staff was in-serviced by the		
		s of Parkinson ' s Disease,			Director of Nurses/Regional Nurse		
		ease, urinary retention, and			Consultant by 8/11/17 on applying a		
	history of urinary trac	ct infections.			catheter strap to relief tension of the		
					catheter tubing and maintaining the		
		mission skin assessment			catheter bag off the floor.		
	dated 5/21/17 read no areas of concern to his				Resident #20 will have catheter care at		
	urethra.				catheter tubing will be secured to the th		
	Λ review of Pesident	#20 significant change			using a leg strap and assessed every s and documented on the Treatment	11111	
		MDS) dated 6/8/17 indicated			Record (TAR) by the assigned nurse to		
		Mental Status (BIMS) of 2			ensure the care plan is being followed.		
		nitive impairment with no			constant and can o praints a configuration		
	behaviors. He was co				The direct care staff was re-educated b	γ	
	assistance with all his	s activities of daily living			the administrator on 7/18/17 on the		
	(ADLs) and coded as	s having a urinary catheter.			importance of reviewing the care guide		
	The Care Area Asses	ssment for his urinary			daily for updates and to understand the	;	
	catheter referred read	der to his care plan.			expected outcome of the residents care		
					Care guides for each resident are locate	ed	
		#20 's care plan dated			on the inside of their closet door.	ſ	
	6/8/17 read the follow				Upon hire the direct care staff will be		
		urinary catheter due to			educated on care guides, its purpose a	na	
		prostate cancer. Resident			their location.		
	-	of stretching his tubing in move about. He needed staff			The nurse aides will use the care guide for communication of care needs	j I	
		atheter care and urinary bag			regarding catheter care and catheter		
		nistory of frequent UTI's.			tubing securement.		
	Janpaning. Ho Had all				Residents with urinary catheters will be	, 	
	Interventions include	d:			reviewed in PAR weekly to ensure	ĺ	
		tubing is secured to his thigh			appropriate documentation is in place.	ſ	
		3			The Director of Nurses/Unit Manager w	/ill	
	A review of Resident	#20 's undated care guide			report findings to the monthly Quality	ſ	
	did not include the in	tervention of ensuring the			Assurance committee for 3 months for		
	catheter tubing is sec	cured to his thigh.			continued quality improvement.	ĺ	
	In an observation on	07/17/17 at 9:00 AM,					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	ARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159	1 0112112011		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLE		
F 282	catheter bag attache frame resting on the In an observation on Resident #20 was lyi partially un-obstructii left thighs. There was securement device to catheter was attache frame with the bag re no observed blood in urine appeared pale. In an observation on Resident #20 was lyi bag was attached to resting on the floor. Thinged urine in his call In an observation and 10:23 AM, Nursing A had worked at the fapulled back Resident observed anchoring stated she was not a should be anchored was instructed to ma attached to his bed be bag should not be lyi stated in the past who Resident #20 she was his urinary bag. She	ng in a low bed with urinary d to the right side of his bed floor. 07/17/17 at 12:10 PM, ng in a low bed with a sheet ng the view of his right and is no observed catheter of either thigh, the urinary d to the right side of the bed esting on the floor. There was in the urinary tubing but his yellow with white sediment. 07/18/17 at 10:21 AM, ng in a low bed. His catheter the left side of his bed frame There was observed blood	F 28				
	#2 stated the aides of	/18/17 at 10:38 AM, Nurse lean his catheter and she er daily to ensure there were					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION 3	` '	(X3) DATE SURVEY COMPLETED		
		345288	B. WING			C 07/21/2017	
	ROVIDER OR SUPPLIER	CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159		, 0.72.720.1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUS CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 282	In an interview on 0' stated she started ir assigned Resident # he did not have a let leg. In an observation or Resident #20 was ly urinary catheter bag his bed frame restin In an observation ar 9:30 AM, NA #2 staffacility for one year a Resident #20. Durin #20 's catheter care his urinary catheter During an observation catheter care, she cand cleaning his tub clean the entirety of to further reveal his testicles and foreski extending from the uthe shaft of his penisinches in length. NA like that when he was 2016. In an interview on 0' stated she applied as leg yesterday aroun.	#2 stated the aides had not leter was not anchored. 7/18/17 at 3:30 PM, Nurse #1 a January of 2017 and was #20 on 7/17/17 and thought g strap because it irritated his attached to the right side of g on the floor and interview on 07/19/17 at led she had worked at the leand she was assigned g an observation of Resident et and she was assigned g an observation of Resident et and she was assigned g an observation of Resident et and she was assigned g an observation of Resident et and she was assigned g an observation of Resident et and she was assigned g an observation of Resident et and she was assigned g an observation of Resident et and she was assigned g an observation of Resident et an of Resident #20 's leaned around his urethra ing. She did not attempt to his penis. NA #2 was asked penis by pushing back his n. Observed was a penile tear urethra down the underside of s measuring approximately 2 at 2 stated his penis was not as admitted in November 7/19/17 at 9:50 AM, Nurse #2 aleg strap to Resident #20 's dd 11:00 AM on 7/18/17.	F 28	32			
	Resident #20 's urir secured in place wit	nary catheter tubing was h a leg strap.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345288		B. WING		C 07/21/2017	
	ROVIDER OR SUPPLIER A ESTATES SKILLED CA	ARE		1	TREET ADDRESS, CITY, STATE, ZIP CODE 404 S SALISBURY AVENUE SPENCER, NC 28159		2172011
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 282	nurse stated she com	e 26 20/17 at 2:40 PM, the MDS upleted Resident #20 's last 6/8/17. She stated she did	F	282			
	not verify there was a Resident #20 's close	on updated care guide in et including the intervention y catheter was secured to					
	the Urologist who sav stated some penile er long term urinary cath would have been the not ensuring the use	ew on 7/20/17 at 11:45 AM, v Resident #20 on 6/26/17 rosion was expected from neter however a 2-inch tear result of trauma or the staff of a leg strap to prevent the bag tugging on his catheter.					
	Resident #20 's physexpectation that Resident	ew on 07/21/17 at 9:45 AM, sician stated it was her dent #20 's urinary catheter t tension and possible ion.					
F 309 SS=D	followed the care plan the intervention of sec his thigh using a leg s injury.	ner expectation the staff of and the care guide include curing his urinary catheter to etrap to prevent tension or PROVIDE CARE/SERVICES	F	309			8/18/17
	applies to all care and residents. Each residents	damental principle that d services provided to facility dent must receive and the he necessary care and naintain the highest					

NAME OF PROVIDER OR SUPPLIER MAGNOLIA ESTATES SKILLED CARE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	COMPLETED		
MAGNOLIA ESTATES SKILLED CARE STREET ADDRESS, CITY, STATE, ZIP CODE			345288	B. WING		C 07/21/2017	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 27 practicable physical, mental, and psychosocial well-being, consistent with the resident's			ı		1404 S SALISBURY AVENUE	1 07/21/2017	
practicable physical, mental, and psychosocial well-being, consistent with the resident's	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	O BE COMPLETION	
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: Based on observation, record review, resident interview and staff interviews the facility failed to provide a fluid restriction as ordered by the physician for 1 of 1 resident (Resident #62) that was reviewed for dialysis. Findings included: Findings included: Nursing staff will be in-serviced by 8/18/17 on protocol for fluid restriction by the Registered Diction (RD).	F 309	practicable physical, well-being, consister comprehensive asset 483.25 Quality of care Quality of care is a function applies to all treatmet facility residents. Base assessment of a resist that residents receive accordance with protogractice, the comprecare plan, and the residents residents with profest the comprehensive pland the residents' god (I) Dialysis. The faci residents who requires services, consistent of practice, the composite of practice, and the respective of practice, the composite of practice, and the respective of practice, and the respective of practice, and the respective of practice of practice of practice, and the respective of practice of prac	mental, and psychosocial at with the resident's assment and plan of care. The system and plan of care and and care provided to sed on the comprehensive dent, the facility must ensure the treatment and care in ressional standards of thensive person-centered sidents' choices, including following: That the pain management is the who require such services, assional standards of practice, the person-centered care plan, the dialysis receive such with professional standards or enemsive person-centered sidents' goals and This not met as evidenced as or record review, resident the terviews the facility failed to oftion as ordered by the esident (Resident #62) that	F 30	Resident #62 no longer resides in the facility. There is one resident in the facility at time on fluid restriction. Nursing staff will be in-serviced by 8/on protocol for fluid restriction by the	this	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG	, ,	E SURVEY IPLETED	
		345288	B. WING		0.	C 7/21/2017	
NAME OF P	ROVIDER OR SUPPLIER	0.0200		STREET ADDRESS, CITY, STATE, ZIP COD	•	721/2017	
THANKE OF TH	NOVIDER OR OUT FEER			1404 S SALISBURY AVENUE	_		
MAGNOLI	A ESTATES SKILLED	CARE					
				SPENCER, NC 28159			
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 309	Continued From pa	ge 28	F 3	809			
	-	es included end stage renal					
	_	ce on renal dialysis and heart		The physicians order for fluid	restriction		
	failure.	oo on ronal dialyolo and noall		will be verified by the nurse, t			
				include the volume or range of			
	A quarterly minimu	m data set (MDS) dated		permitted during 24 hour peri			
		nt #62 revealed he received					
	dialysis treatment,	was on a therapeutic diet,		The Dietary Department will be	e notified by		
	required supervisio	n with his activities of daily		the nurse using Diet			
	living (ADL's) and	his cognition was intact.		Order/Communication Form,			
				notify the Registered Dietician			
		sician orders for Resident #62		the amount of fluid to be prov			
		trays and noted on the tray ca					
		striction per day, dietary to give		calculate the remaining amou			
		als and nursing to give 240		be provided by nursing and w allotted for each shift.	nat is		
		cc) every shift. An order for Prostat 30 milliliters (ml)		anotted for each shirt.			
		order initiated on 6/28/17 for 1		The fluid intake will be docum	ented by the		
	· ·	every day for a supplement.		nurse on the intake sheet to r			
		recy day io a cappionionii		document the total fluid intake			
	A care plan for Res	ident #62 that was updated on		hour period according to phys			
		e was on hemodialysis due to		and maintained as long as the			
		I failure and was at increased		on fluid restrictions.			
	risk for fluid deficit i	related to diuretic use and					
		ns included to encourage		The nursing staff will be notifi			
		id restriction as ordered, but		care plan and care guide rega	arding fluid		
		t with it and monitor residents		restriction.			
	fluid intake as orde	red.					
		2047		When a resident is on fluid re			
	A review of the July			resident will be monitored by			
		rd (MAR) for Resident #62		any issues identified will be re			
		or 32 oz. fluid restriction in a e times on the MAR were 6:00		weekly PAR meeting and follomonthly QA committee for 3 r			
	·	0:00 pm and there was a		continued quality improvemen			
		s for each of these times. The		Softinaca quanty improvemen			
		nsumed for each of these time					
		cumented. There was an entry					
		lay at 2:00 pm and there was a					
		for this time. There was an					
		ml at 1:00 pm and 8:00 pm					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		IDENTIFICATION NUMBED:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345288	B. WING _			C 7/21/2017	
	ROVIDER OR SUPPLIER A ESTATES SKILLED CA			STREET ADDRESS, CITY, STATE, ZIP COD 1404 S SALISBURY AVENUE SPENCER, NC 28159		7/21/2017	
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 309	An observation and in Resident #62 revealed that was approximate table. Resident #62 stimes per week. He swas on any kind of didialysis told him not tresident added he is drinks. He explained water and ice to keep t. An interview on 7/20/Assistant (NA) #1 rev Resident #62. She st times a week. The Nobeing on any diet or fresident #62 had a vhe asked for water and NA #1 provided addit nurse told her Resider estriction and that whe she had an assignment didn't say he was provide him with a way. An interview on 7/20/revealed she was on dial be on a fluid restriction supply him with a sm during the day. She excould give him 360 constated she recorded in meals or a snack in the same could give him 360 constated she recorded in meals or a snack in the same could give him 360 constated she recorded in meals or a snack in the same could give him 360 constated she recorded in meals or a snack in the same could give him 360 constated she recorded in meals or a snack in the same could give him 360 constated she recorded in the same could give him 360 constated she recorded in the same could give him 360 constated she recorded in the same could give him 360 constated she recorded in the same could give him 360 constated she recorded in the same could give him 360 constated she recorded in the same could give him 360 constated she recorded in the same could give him 360 constated she recorded in the same could give him 360 constated she recorded in the same could give him 360 constated she recorded in the same could give him 360 constated she recorded in the same could give him 360 constated she recorded in the same could give him 360 constated she recorded in the same could give him 360 constated she recorded in the same could give him 360 constated she recorded in the same could give him 360 constated she recorded in the same could give him 360 constated she recorded in the same could give him 360 constated she recorded she same could give him 360 constated she recorded she same could give him 360 constated she same cou	nterview on 7/20/17 with dhe had a 16 ounce cup ly half full on his bedside tated he went to dialysis 3 tated he wasn't sure if he et, but the Dietitian at o eat any bananas. The supposed to watch what he some of the staff bring him in his room and some don' 17 at 9:50 am with Nursing ealed she was familiar with ated he went to dialysis 3. A was unaware of resident luid restriction. She added water pitcher in his room and information that the ent #62 was on a fluid as her mistake. She stated and a fluid restriction or not to	F3	09			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345288	B. WING _			I	C 21/2017
	ROVIDER OR SUPPLIER	ARE	•	STREET ADDRESS, CITY, STATE, ZIP COL 1404 S SALISBURY AVENUE SPENCER, NC 28159	DE		-
(X4) ID PREFIX TAG			ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 309	provided by the Direct reviewed for 6/19/17 included the amount with meals and between include the fluids here with his medications. The roster document restriction on the followard of the foll	tor of Nursing (DON), was through 7/19/17. The roster of fluids the resident drank then meal snacks. It did not drank from his water pitcher, or his ordered supplements. The ded excess of his 32 oz. fluid owing days: 6/21 - 1080 cc ' 7/3 - 1200 cc ' s, 7/12 - 1700 ' s, 7/16 - 1680 cc ' s and '	F3	09			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345288	B. WING				C 21/2017
	ROVIDER OR SUPPLIER A ESTATES SKILLED CA	ARE		14	REET ADDRESS, CITY, STATE, ZIP CODE 104 S SALISBURY AVENUE PENCER, NC 28159		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 312 SS=D	(DM) revealed he was potassium diet with la fluid restriction. The most provide the resider fluid per meal. An interview on 7/21/revealed that according card he would receive meal. An interview on 7/21/revealed that Resider cups of fluid with each had been placed on him starting as the DI didn't realize he had 8 oz. of fluids with each 483.24(a)(2) ADL CADEPENDENT RESID (a)(2) A resident who activities of daily living services to maintain gersonal and oral hygometric than the services to maintain gersonal and oral hygometric than the services to maintain gersonal and oral hygometric than the services to maintain gersonal and oral hygometric than the services to maintain gersonal and oral hygometric than the services to maintain gersonal and oral hygometric than the services to maintain gersonal and oral hygometric than the services to maintain gersonal and oral hygometric than the services to maintain gersonal and oral hygometric than the services to maintain gersonal and oral hygometric than the services to maintain gersonal and oral hygometric than the services to maintain gersonal and oral hygometric than the services to maintain gersonal and oral hygometric than the services to maintain gersonal and oral hygometric than the services to maintain gersonal and oral hygometric than the services to maintain gersonal and oral hygometric than the services that the services tha	ed by the Dietary Manager is on a regular, low arge portions and a 1000 cc heal tray card documented at with two 8 oz. glasses of 17 at 8:37 am with Cook #1 and to Resident #62 's tray is two 8 oz. cups of fluid per 17 at 8:39 am with the DM at #62 received two 8 oz. In meal. He stated that this his meal tray card prior to what the facility and that he a physician 's order for only ch meal. RE PROVIDED FOR ENTS Is unable to carry out greceives the necessary good nutrition, grooming, and giene. It is not met as evidenced ew, observations and staff failed to clean dirty esidents reviewed for and failed to provide do for 2 of 7 residents for Daily Living (Resident)		312	Resident #24 (Resident #27 per Stage Sample List) no longer resides in the facility. Resident #33 had a shower on 7/17/17 Consistent assignments were implemented on 8/1/17 to ensure continuity of care and completion of ADL s. Showers will be documented of shower sheets 2 times per week. The shower sheets will be kept by the hall		8/18/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_			С	
		345288	B. WING _			07	21/2017	
NAME OF P	ROVIDER OR SUPPLIER			S1	FREET ADDRESS, CITY, STATE, ZIP CODE			
MAGNOLI	IA ESTATES SKILLED	CARE		14	104 S SALISBURY AVENUE			
WAGNOL	IA ESTATES SKILLED	CARE		S	PENCER, NC 28159			
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 312	Continued From partial Resident #24 with a current diagnoss muscle weakness, Resident #24 had a updated 5/7/17 for Activities of Daily Liextensive assistance included for a bath/and nail care and s. The resident's quarth 5/20/17 revealed the cognitively impaired term memory impaired term memory impaired term terminal soft diem. Nursing notes were revealed there was of care. Review of the ADL revealed that the resident was of care. Review of the ADL revealed that the resident was of care. Review of the show that the resident was showers a week on the current and the showers a week on the current and the current	ge 32 ras admitted on 2/18/10 with res of dysphagia, malnutrition, and dementia. a care plan in place last staff assistance with all riving (ADL's) and required re with ADL's. Interventions shower be given as scheduled rat the resident was severely d and had short term and long rement. The resident required re with bed mobility, rig, eating, and total care with red toilet use and total care resident was always incontinent redder. The resident was on a ret and received feeding tubes. Reviewed from 7/3/17 and red documentation of refusal flow sheet for July, 2017 resident received "bathing" on resident received		312		ch e. ers s d. ds s to e ng re		
	7/13/17, 7/14/17, 7/ The flow sheet did bathing was given. Review of the show that the resident washowers a week on shower sheets indic 7/18/17 that the resident washower sheets indic 1/18/17 that the resident washower sheets indicated by the shower sheets indicated by the sheet sheet sheets indicated by the sheet sheet sheets in the sheet sheet sheets in the sheet sheet sheets in the sheet sheet sheet sheet sheets in the sheet sheet sheet sheet sheets in the sheet she	/15/17, 7/16/17 and 7/18/17. not indicate what kind of /er schedule sheets revealed as scheduled to have 2						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345288	B. WING _			C 07/21/2017
	ROVIDER OR SUPPLIER	ARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159		0112112011
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 312	Continued From pag	e 33	F 3	12		
	Review of the shower resident was schedul but got a shower on care/shaving and shifts. There were no slimonth of 6/2017. The resident was obtained bath with the assassistant #1 and Nurresident was given a clothes were change. Nursing Assistant #2 at 10:45 AM. She stamainly on the weeke usually scheduled for person would call ou on the day shift for the stated many times it everything done for the in the mornings shere residents, feed residistated that she would complete the small thoral care but sometime the small things if the working. She stated today on 2nd shift. She this resident got a she usually give resident schedule but occasion resident a total bed to the Nursing Assistant #1 at 2:57 PM. She stated resistance with care scratched her before	er sheets revealed that the led for a shower on 7/18/17 7/19/17 and that nail ower was completed by NA nower sheets for the entire served on 7/19/17 at 9:53 care. The resident received a sistance from Nursing rsing Assistant #2. The bed bath and the resident's d. was interviewed on 7/19/17 ated that staffing was rough nds. She stated that they are r 4 NA but that sometimes 1 t and that left them with 3 NA ne whole nursing home. She was really hard to get he resident. She stated that would round, change ents and get them up. She digo back around and nings like clean nails and do nes she just couldn't get to				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION B	(X3) DATE SURVEY COMPLETED	
		345288	B. WING		C 07/21/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159	07/21/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 312	onto things sometime resident got showers wasn't sure of the da was pretty heavy" and Nurse # 1 was intervishe stated that the reassistance. The resident has shower of this shower. She saware of a time that it completed for this reaknows last week that if the resident was now was given a bed bath combative at times. Some small care are but they got to the macare and bathing. NA #4 (worked secondary 17/19/17 at 4:18 PM. Some small care are but they got to the macare and bathing. NA #4 (worked secondary 17/19/17 at 4:18 PM. Some small care are but had never reasonable the resident was school to the show they also would try they also would	es. She stated that the on second shift but she y. She stated that "the floor d they have so much to do." Jewed on 7/19/17 at 3:21 PM. esident required total dent's showers were d shift. The resident would be hair and they would take him stated that she was not make the showers were not sident. She stated that she the resident had a shower. It given a shower then he had and the resident was she stated that she doesn't gh NA's but they did the best and that there were probably as the NA could not get to a gior things like incontinence and shift) was interviewed on She stated that the resident noce with ADL's. She stated esident could be resistive to efused care. She stated that eduled for showers on	F 31		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345288	B. WING		C 07/24/2047
	ROVIDER OR SUPPLIER A ESTATES SKILLED (STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159	07/21/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 312	showers up. For exischeduled for a showould try to do 2 shother 2 on Wednesd all of them on Tuesd sometimes that whe there wouldn't be ershe couldn't always planned the previous times, resident were of a shower if they of a shower at the redocumented on if the bed bath. They also nurses and they do bathing when a resistance where shower days, the state shower sheets a Resident were supply week. Residents we bed bath every day. She stated that she team" to get all the stated that sometim will forget to sign off She has had up to a shift and that when from other NA that a She stated she was resident was not get She stated that she	she would try to divide the ample, if 4 residents were wer on Tuesday then she owers on Tuesday and the day if she wasn't able to get to day. She stated but en she comes on Wednesday hough NAs working again and get to the showers as is day. She stated that other e just given a bed bath instead couldn't get to them. She dn't say if showers were being his resident. Sing was interviewed on She stated that the shower nursing stations and should be the resident got a shower or full oneed to report it to the cument it electorally under dent was given a bath. On the last are supposed to sign on the farm at the nursing station. Hosed to get showers twice a last the nursing station. Hosed to get showers twice a last the nursing station. Hosed to get showers twice a last the nursing station. Hosed to get showers twice a last the nursing station. Hosed to get showers twice a last the nursing station. Hosed to get showers twice a last the nursing station. Hosed to get showers twice a last the nursing station. Hosed to get showers twice a last the nursing station. Hosed to get showers twice a last the nursing station. Hosed to get showers twice a last the nursing station. Hosed to get showers twice a last the nursing station. Hosed to get showers twice a last the nursing station. Hosed to get showers twice a last the nursing station. Hosed to get showers twice a last the nursing station. Hosed to get showers twice a last the nursing station. Hosed to get showers twice a last the nursing station. Hosed to get shower the last the nursing station and should be last to them. She down and should be last to them. She down and should be last to the nursing station and should be last	F 31		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345288	B. WING		07/21/2017	
	ROVIDER OR SUPPLIER A ESTATES SKILLED C	ARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETION	
F 312	Continued From pag	e 36	F 312	2		
	stated that the reside 7/19/17. He stated the overlooked earlier in realized it, he gave the 7/19/17. He stated the stated that he would on the shower sheets stated that they just I care for to get to ever the resident got a sheast week but that aft shower, the resident "Nursing Assistant #4 resident on second sinterviewed on 7/21/1 that she could not reresident a shower on The administrator was missed or refused to be completed as a shower or more to be and that there was on was missed or refused to be completed as a 1b. Resident's #24 in from 7/3/17 and reversided that the resident for the ADL filter revealed the ADL filter re	17 at 1:59 PM. She stated member if she gave this a Friday or not. as interviewed on 7/21/17 at d she expected that 2 pe completed for residents communication if a shower led. Nail care was supposed a part of a shower.				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	' '	OMPLETED
		345288	B. WING			C 07/21/2017
	ROVIDER OR SUPPLIER	ı		STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159	<u> </u>	07/21/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 312	that the resident was showers a week on shower sheets indic 7/18/17 that the resi and nail care and she Review of the shower resident was schedulut got a shower on care/shaving and she #3. There were no smonth of 6/2017. Resident #24 was on AM during morning a bath but nail care resident nails were I substance under the hands were slightly had little movement. Nursing Assistant #2 at 10:45 AM. She st mainly on the weeked usually scheduled for person would call out on the day shift for the stated many times it everything done for in the mornings she residents, feed residents, feed residents, feed residents, feed residents are but sometiful the small things if the working. Nursing Assistant #2	Tuesdays and Fridays. The ated that on 7/11/17, 7/14/17, dent was not given a shower aving was not completed. er sheets revealed that the alled for a shower on 7/18/17 7/19/17 and that nail ower was completed by NA shower sheets for the entire beserved on 7/19/17 at 9:53 care. The resident was given was not performed. The ong and had a black em bilaterally. The resident's contracted and the resident	F 31			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) N IDENTIFICATION NUMBER: A. BU		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345288	B. WING		C 07/21/2017
	ROVIDER OR SUPPLIER	ARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159	1 01/21/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 312	scratched her before did not refuse care bonto things sometime resident got showers wasn't sure of the dasupposed to do naile that this morning she She stated that "the they have so much to time that nail care was resident. She also at have been complete that nail care was an completed sometime enough help and it wanother person to rocare and oral care on many days she does was so much to do. Nurse # 1 was intervished shaded that the reassistance. She stated that the reassistance. She stated that small care areas the got to the major thing bathing. NA #4 (worked seconor) 7/19/17 at 4:18 PM. supposed to happendays. They documer nail care and shaving the shower sheet. Silicare one day last we exact date. She start	e 38 e. She stated that the resident out the resident would grab es. She stated that the son second shift but she by. She stated they were care with morning care but was nervous and forgot. If floor was pretty heavy and o do. She wasn't sure the last as completed for this dided that nail care should do this morning. She stated area that may not be as because there wasn't would be nice if there was und and do things like nail in residents. She stated that in't get a break because there with the sident required total ed that she doesn't think A's but they did the best they at there were probably some NA could not get to but they get like incontinence care and and shift) was interviewed on Nail care and shaving was as needed and on shower at electronically for showers, g. They also would try to sign he stated that she didn't cut his sident was jerking a bit but	F 31	2	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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		345288	B. WING _			07/	21/2017	
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
MAGNOLI	A ESTATES SKILLED CA	ARE		1	1404 S SALISBURY AVENUE			
MAGNOLI	A LOTAT LO SKILLLO OF	W.C.		,	SPENCER, NC 28159			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION DATE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	AIE	DATE	
					·			
F 312	Continued From page	. 30		312				
1 312				312	•			
		the nurse since he's been						
	back from at the nosp	ital that he refused care.						
	The resident #24 nails	s were observed on 7/19/17						
		ent's nails were still long						
		nce under them bilaterally.						
	and had black cabeta	nee ander mem shaterany.						
	Nursing Assistant #2	was interviewed again on						
		She stated that the resident						
	#24 nails were dirty a	nd long and that she would						
	try to cut them today.	She stated that the nails on						
	the left hand were cle	aner than the right hand but						
	both were long.							
		ng was interviewed on						
		She stated that when it's the						
	-	, the resident was supposed						
	to also have nail care	completed too.						
	NA #3 was interviewe	d on 7/21/17 at 4:36 PM. He						
		24 was given a shower on						
		at the shower sheet was just						
	overlooked earlier in h	-						
	realized it, he gave th	e resident a shower on						
	7/19/17. He stated that	at he worked 2nd shift. He						
	stated that he didn't e	ven touch the resident's						
	nails on 7/19/17 and t	old the nurse. He stated						
		that she would get to it when						
	she could.							
	The administration	n intensioused == 7/04/47 -+						
		s interviewed on 7/21/17 at						
	11:25 AM. She stated	e completed for residents						
		mmunication if a shower						
		d. Nail care was supposed						
	to be completed as a							
		processing the second s						

	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER		(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
		345288	B. WING				C 07/21/2017	
	ROVIDER OR SUPPLIER A ESTATES SKILLED CA			1	TREET ADDRESS, CITY, STATE, ZIP CODE 404 S SALISBURY AVENUE PENCER, NC 28159	<u> </u>	21/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 312	cumulative diagnoses and seizures. His quarterly Minimur indicated Resident #3 impairments with vert He was coded with to and incontinent of both Resident #33 last rev indicated he required assistance of two states refusal of care, aggretimes with his activitie was care planned for bathing and reappora	admitted on 1/22/15 with a of dx anoxic brain injury In Data Set dated 5/16/17 B3 had severe cognitive coal and physical behaviors. Italian assistance for bathing well and bladder. Itsed care plan dated 5/23/17 extensive to total ff members due to his ssion and combativeness at less of daily living (ADLs). He two staff assistance when each for refusals. Ithe daily shower sheets as the severy Monday and	F	312	DEFICIENCY)			
	electronic Bath Check following: June Review: 6/1/17- no documente received a bed bath 6 6/4/17-shower 6/5/17-bed bath 6/8/17 bed bath 6/9/17 sponge bath 6/12/17-sponge bath	ed bath or shower but						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345288	B. WING		C 07/21/2017	
	ROVIDER OR SUPPLIER	ARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION	
F 312	7/6/17 7/10/17-bed bath 7/13/17-shower 7/17/17 shower 7/20/17 bed bath In a telephone interviresponsible party (RF was getting his show She stated staffing w Resident #33 require In an interview on 7/2 Assistant (NA) stated electronic record thei try to sign the showe many times it 's not of that staffing has been times they can 't give showers. NA #4 state resident was given a shower if they staff w shower them on their In an interview on 7/2 stated that often the instead of showers b enough staff. In an observation on Resident #33 was se the hallway. He appe	ew with Resident #33 's P) stated she did not feel he ers as often as he should. as an ongoing problem and d two staff to shower him. 19/17 at 4:18 AM, Nursing I staff document in the r showers. She stated they r sheets when they can but documented. She stated in hard recently and many e all their assigned residents and there were times when a bed bath instead of a as unable to get to them to r shift. 19/17 at 9:03 AM, NA #6 resident was given bed baths ecause there was not	F 312			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		TE SURVEY MPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE	07	21/2017	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE	
F 312	Continued From page	2 42	F 3	12			
	of Nursing (DON) cor	0/17at 8:20 AM, the Director firmed the facility had two ch room had its own shower					
	Resident #33 was ear He appeared absent incontinence. He was weather. When asked today, he responded	on on 7/20/17 at 1:00 PM, ting lunch in the day room. of odors or evidence of clean and dressed for I if he received a shower yes. He was cooperative or physical behaviors.					
	stated she was assigned in the stated it was not uncooperative today I time to complete here. break. NA #1 stated inability to complete here.	out that she did not have assignment or take a lunch she had not reported her assignment to anyone ort to the second shift aide					
	5/1/17 to present inclu	ggressive and agitation but					
	stated it was her experence his showers a having active seizure also expectation that shower today on section 483.25(e)(1)-(3) NO (1)	CATHETER, PREVENT UTI,	F 3	15		8/11/17	
SS=G	RESTORE BLADDER	₹					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	PLE CONSTRUCTION G	, , ,	(X3) DATE SURVEY COMPLETED	
		345288	B. WING			C 7/21/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159		7/21/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 315	(e) Incontinence. (1) The facility must e continent of bladder a receives services and continence unless his or becomes such that to maintain. (2)For a resident with on the resident's comfacility must ensure the indwelling catheter is resident's clinical concatheterization was not indwelling catheter or is assessed for remo as possible unless the demonstrates that catheter and (iii) A resident who entindwelling catheter or is assessed for remo as possible unless the demonstrates that catheter is receives appropriate prevent urinary tractic continence to the ext. (3) For a resident with on the resident's comfacility must ensure the incontinent of bowel in treatment and services bowel function as post This REQUIREMENT by: Based on observations.	ensure that resident who is and bowel on admission d assistance to maintain is or her clinical condition is it continence is not possible in urinary incontinence, based apprehensive assessment, the hat- ters the facility without an is not catheterized unless the addition demonstrates that necessary; ters the facility with an increased apprehensive assessment, and it is the catheter as soon necession in the catheter as soon in the resident's clinical condition at the catheter and services to infections and to restore ent possible. The facility with an increase in the catheter as soon in the resident's clinical condition at the catheter as soon in the resident's clinical condition at the catheter and services to infections and to restore ent possible. The facility with an increase in the catheter as soon in the catheter as soon in the resident's clinical condition at the catheter as soon in the catheter	F 3'	Resident # 20s urinary cather changed on 7/19/17.	ter was		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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		345288	B. WING			07/	21/2017
NAME OF PR	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MAGNOLI	A ESTATES SKILLED CA	ARF		14	404 S SALISBURY AVENUE		
MACROLI	A LOTATEO GIVILLED GA	1112		S	PENCER, NC 28159		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 315	Continued From page	e 44 neter as ordered and failed	F	315	There are no other residents in the faci	lity.	
		s in the appearance of the			There are no other residents in the faci with urinary catheters.	шу	
	_	tion site (urethra) for 1			Resident #20□s physician was notified	of	
		esidents reviewed for urinary			the change of condition to the resident	∃s	
	catheters. The finding	js included:			penis on 8/7/17. The Nurse Aides will be in-serviced on		
	Resident #20 was ad	mitted on 11/22/16 with			urinary catheter care by the Director of		
		s of Parkinson 's Disease,			Nurses/Regional Nurse Consultant by		
		ease, urinary retention, and			8/11/17 to include retracting the foreski	n if	
	history of urinary trac	t infections.			needed, clean the penis, clean the urethra, and clean the catheter from to	n to	
	A review of Resident	#20 's skin assessment on			bottom holding and not putting tension		
		3/16 read no areas of			the catheter. Rinse, dry gently and sec		
	concern to his urethra	a.			catheter with leg strap. Hanging the catheter bag appropriately and notify the	ıe	
		#20 ' s December 2016			charge nurse of any changes.		
		I his urinary catheter was to			The nurses will be educated by the		
	be changed monthly	on the 30th of every month.			Director of Nurses/Regional Nurse Consultant by 8/11/17 on documentation	on	
	A review of Resident	#20 ' s December 2016			of change of condition with notification		
	treatment administrat catheter was changed	ion (TAR) read his urinary d on 12/30/16.			physician and responsible party.		
					The 24 hour nursing report will be		
		#20 's January 2017 TAR			reviewed daily by the Director of	f	
	read his urinary cathe 01/30/17.	eter was changed on			Nurses/Unit Manager for all changes of condition and will be reviewed in daily	1	
	0 1/00/11 .				morning clinical meeting with the		
		#20 ' s February 2017 TAR			administrator for physician and		
		is catheter was changed at			responsible party notification.		
	any time during the m	ionui.			The Director of Nurses will take all issu and concerns related to physician and	८ 5	
	A review of Resident	#20 ' s March 2017 TAR did			responsible party notification to the		
		atheter was changed at any			monthly Quality Assurance Committee		
	time during the month	1.			monthly for 3 months.		
		4/3/17 at 2:05 AM read					
		ted to have hematuria (blood ne sample was obtained.					
	in the unite) and a un	ne sample was obtained.					

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F 315	Resident #20 was sand increased confichronic indwelling used and overall declining his GU observation were no documented. Resident #20 's ured. A nursing note date #20 's was leaking colored urine return UTI. A review of Resider read his urinary catt monthly of the 17th 2017 TAR read it was a review of Resider assessment dated (showered and no sland momention of any area #20 's penis or ured. A nursing note date Resident #20 was sadmitted with hemato the facility on 5/2. A review of Resider dated 5/21/17 indicated UTI and hematuria. physician note indicated in the same properties of the same properties.	ress note dated 04/05/17 read teen for follow up for a fever usion. The note referenced his rinary catheter with hematuria g health. The PA referenced of clear yellow urine. There ad staff concerns related to eithra or urinary catheter. d 4/7/17 at 5:28 AM, Resident It was changed with Cola . He was being treated for a the was being treated for a the was to be changed of each month and his April as changed on 4/17/17. at #20 's weekly skin 04/24/17 read his had been kin issues noted. There was ureas of concern to Resident chra. d 5/16/17 at 10:44 PM read tent to the hospital and turia and a UTI. He returned	F 318			
	seen by a urologist seek urological care another town. The r					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) N IDENTIFICATION NUMBER: A. BU		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 315	Continued From page	e 46	F 31	5	
	changed the 17th of e A review of his re-adr dated 5/21/17 read no urethra.	d 5/21/17 read was to be			
	5/26/17 read the visit and hospitalization. T was seen by urologis orders and staff report sediment in his urinar read his urinary cathe	was for a follow up for a UTI the note read Resident #20 t in the hospital with no new ted a large amount of ty bag. The GU assessment eter was in place with a large He was currently on an			
	urinary catheter was	6/7/17 at 8:11 AM read his draining pale yellow milky liment. A note was left for			
	Resident #20 was secourse of antibiotics f had an indwelling urin urology in the hospital looking urine. His GU an indwelling urinary of sediment but no blidescribed as yellow. staff concerns related PA left orders for staff urinary catheter.	erress note dated 6/7/17 read en for follow up after his or a UTI. The note read he harry catheter and saw il. Staff reported a thick milky assessment read he had catheter with a large amount good and the urine was There was no mention of I his urethra or penis. The f to change Resident #20 's			
	A review of Resident catheter was change	#20 ' s TAR indicated his d on 6/8/17.			

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	ROVIDER OR SUPPLIER A ESTATES SKILLED CA	ARE	1	1	TREET ADDRESS, CITY, STATE, ZIP CODE 404 S SALISBURY AVENUE SPENCER, NC 28159	1 0111	21/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 315	Minimum Data Set da Brief Interview for Me meaning severe cognote behaviors. He was consistance with all his (ADLs) and coded as The Care Area Assess catheter referred read A review of Resident 6/8/17 read the follow *Resident #20 had a urinary retention and #20 had a history of attempts to stand or massistance with his catemptying. He had a him Interventions included *Observation of Residirritation and redness *Ongoing assessment his urine *Assessment of Residirritation and redness *Ongoing assessment #20 *Provide catheter care *Change his catheter *Obtain Urinalysis are *Ensure the catheter A review of Resident indicated his urinary of 6/17/17. A nursing note dated	#20 significant change ated 6/8/17 indicated his intal Status (BIMS) of 2 ditive impairment with no oded for extensive activities of daily living having a urinary catheter. Sment for his urinary der to his care plan. #20 's care plan dated ving problem: urinary catheter due to prostate cancer. Resident stretching his tubing in move about. He needed staff atheter care and urinary bag distory of frequent UTI's. d: dent #20 's skin daily for to the color and clarity of dent for sign of a UTI perineal care as needed to a Urologist as needed e as ordered and as needed	F	315			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345288	B. WING		C 07/21/2017	
	ROVIDER OR SUPPLIER	ARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159	1 0112112011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 315	Continued From pag was lying at his beds		F 315			
	difficulty. There was trauma of assessment A review of the urologous this was the same ur Resident #20 to his phospital discharge. H#20 on 6/26/17 who responsible party (RI last saw Resident #2 a hospitalization. The catheter change more	gy note dated 6/26/17 read				
	that his catheter was were no new orders. A review of Resident	draining clear urine. There #20 's July 2017 TAR read vas changed on 7/17/17.				
	In an observation on Resident #20 was lyi	07/17/17 at 9:00 AM, ng in a low bed with urinary d to the right side of his bed				
	Resident #20 was lyi partially un-obstructin left thighs. There was securement device to catheter was attache frame with the bag re no observed blood in urine appeared pale	07/17/17 at 12:10 PM, ng in a low bed with a sheet ng the view of his right and is no observed catheter of either thigh, the urinary d to the right side of the bed esting on the floor. There was the urinary tubing but his yellow with white sediment.				
	1	07/18/17 at 10:21 AM, ng in a low bed. His catheter				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345288	B. WING _			C 07/21/2017	
	ROVIDER OR SUPPLIER	ARE		STREET ADDRESS, CITY, STATE, ZIP CO 1404 S SALISBURY AVENUE SPENCER, NC 28159		7772172017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 315	resting on the floor. It tinged urine in his car linged and had worked at the fact pulled back Resident observed anchoring of stated she was not at should be anchored the was instructed to material attached to his bed be bag should not be lyistated in the past which is urinary bag. She perform his urinary car linged to the nurse. In an interview on 07 #2 stated Resident #2 stated she had observed and he rolled stated she had observed she had not told not anchored and not concerns to his penish linged and not concerns to his penish linged Resident #2 he did not have a leg leg. She stated she car linged leg. She stated she car linged leg. She stated she started in assigned Resident #2 he did not have a leg leg. She stated she car linged leg. She	the left side of his bed frame There was observed blood theter tubing. It interview on 7/18/17 at ssistant (NA) #13 stated she cility for 3 months. NA #13 #20 's sheet. There was no device to either thigh. She ware that his urinary catheter to his thigh. She stated she ke sure his urinary bag was ut not aware that his urinary ing on the floor. NA #13 en she was assigned is only instructed to empty was not aware of how to atheter care or what to report was not aware of how to atheter care or what to report was not aware of how to atheter care or what to report was not aware of how to atheter care or what to report was not aware of how to atheter care or what to report was not aware of how to atheter care or what to report was drom side to side. She wed blood in in his urine on stated the aides clean his essed his catheter daily to occoncerns. Nurse #2 stated do her that his catheter was told her about any observed or urethra. 1/18/17 at 3:30 PM, Nurse #1 January of 2017 and was 20 on 7/17/17 and thought strap because it irritated his lid not assess his catheter is but expected the aides to	F3	15			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN		PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345288	B. WING			C 7/21/2017	
	OVIDER OR SUPPLIER	ARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	urinary catheter bag a his bed frame resting. In an observation and 9:30 AM, NA #2 state facility for one year ar Resident #20. During #20 's catheter care, urethra and cleaning attempt to clean the ewas asked to further back his testicles and penile tear extending underside of the shaft approximately 2 inchepenis was not like tha November 2016. In an interview on 07/confirmed she looked daily. She stated she on his admission but today. Nurse #2 state monthly on night shift have been reported whis catheter change. In an interview on 07/#3 stated she worked thought Resident #20 "awhile". She describe "ridge" on his penis beenis in probably a mere and state of the state of	7/18/17 at 3:40 PM, ng in a low bed with his attached to the right side of on the floor I interview on 07/19/17 at d she had worked at the nd she was assigned an observation of Resident she cleaned around his his tubing. She did not entirety of his penis. NA #2 reveal his penis by pushing foreskin. Observed was a from the urethra down the tof his penis measuring es in length. NA #2 stated his t when he was admitted in 19/17 at 9:50 AM, Nurse #2 at Resident #20 's penis thought he had a small tear it did not look like it did d his catheter was changed and the penile tear should when it was observed during	F 3	15			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		345288	B. WING		C 07/21/2017		
	ROVIDER OR SUPPLIER	CARE	1	TREET ADDRESS, CITY, STATE, ZIP CODE 404 S SALISBURY AVENUE SPENCER, NC 28159			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		
F 315	Nurse #6 confirmed worked third shift on changed Resident # past but not recently she documented on urinary catheter Mor #6 stated she did no 07/17/17 as docume an explanation as to TAR that she chang catheter when on in not. She stated she urinary catheter a m observed pus and b noted the penile tea #20 pulled at his cat to the genital area.	ge 51 view on 07/19/17 at 3:10 PM, she worked nights and 17/17/17. She stated she had 20 's urinary catheter in the v. Nurse #6 was reminded his TAR she changed his inday night on 07/17/17. Nurse of change his catheter on ented. She was unable to offer owhy she initialed off on the ed Resident #20 's urinary terview, she stated she did 1 thought she changed his onth or so ago and had lood at his urethra but had not r. Nurse #6 stated Resident heter and scratched himself She stated she was not aware a catheter securement	F 315				
	4:00 PM from Nover included no intakes change in Resident at his urethra. In an interview on 7/stated it was her first assignment after a 3/hall. The Director of were observed asset The DON pulled back and testicles to revestated "it wasn't like stated he may have maybe a little split be	ty incident logs on 7/16/17 at mber 2016 to present regarding any injury or #20 's catheter insertion site 19/17 at 4:20 PM, NA #14 t day back on the 200-hall 8-month rotation on another Nursing (DON) and NA #14 essing Resident #20 's penis. ck Resident #20 's foreskin al the penile tear. NA #14 e that 3 months ago". NA #14 had some bleeding and ut not like what it looks like ed she was unable to recall if					

i i i i i i i i i i i i i i i i i i i		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	COMPLETED	
		345288	B. WING		C 07/21/2017	
	ROVIDER OR SUPPLIER A ESTATES SKILLED	CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE COMPLETION	
F 315	it had worsened sin weeks ago". There were no nurs at 4:59 PM which recatheter was changed. A nursing note date Resident #20's urisecured in place will be secured in place will not see him him to go another use facility. He stated hon 06/26/17. The Use he did not assess Fand was not aware some penile erosion term urinary cathete have been the resuensuring the use of weight of the urinar. In a telephone inter Resident #20's phexpectation that Residered and neede expectation that his	sing notes again until 7/19/17 ead Resident #20 's urinary ged without difficulty. d 7/20/17 at 8:15 AM read nary catheter tubing was th a leg strap. view on 7/20/17 at 11:45 AM, aw Resident #20 on 6/26/17 equest of Resident #20 's RP, in the hospital. The RP wanted prologist who was not near the ne agreed to see Resident #20 Urologist stated during the visit, Resident #20 's penis, urethra of a penile tear. He stated in was expected from long er however a 2-inch tear would lit of trauma or the staff not a leg strap to prevent the by bag tugging on his catheter. view on 07/21/17 at 9:45 AM, ysician stated it was her esident #20 's urinary catheter ent tension, changed as d. She also stated it was her is catheter and insertion site be	F 315			
	and was not aware some penile erosion term urinary cathete have been the resurensuring the use of weight of the urinar. In a telephone inter Resident #20's phexpectation that Respectation that Respectation that his assessed daily and changes such as traurethra.	of a penile tear. He stated in was expected from long or however a 2-inch tear would lit of trauma or the staff not a leg strap to prevent the y bag tugging on his catheter. View on 07/21/17 at 9:45 AM, ysician stated it was her esident #20 's urinary catheter ent tension, changed as d. She also stated it was her catheter and insertion site be she be notified of any auma or tearing to his penis or				
	In an interview on 0	07/21/ at 10:40 AM, the d her expectations were the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		345288	B. WING _		ı	21/2017
	ROVIDER OR SUPPLIER A ESTATES SKILLED CA	ARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159	1 5	
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323 SS=J	HAZARDS/SUPERVI		F3	23		8/18/17
	from accident hazard (2) Each resident recand assistance device	onment remains as free s as is possible; and eives adequate supervision es to prevent accidents.				
	appropriate alternativ bed rail. If a bed or s must ensure correct i	ails, including but not limited				
	from bed rails prior to (2) Review the risks a	and benefits of bed rails with nt representative and obtain				
	This REQUIREMENT by: Based on observatio interviews, and record prevent an avoidable	sident's size and weight. is not met as evidenced ns, Physician and staff ds review the facility failed to fall from mechanical lift 1 of 6 residents reviewed for		Resident #47 no longer resides if facility. Other residents affected were re-assessed on 7/18/17 for the note the Hoyer/mechanical lift and the	eed for	
	cognitively impaired heing weighed by me	# 47 who was severely had a fall with injuries while chanical lift, with only one signed staff after weighing		plans and care guides were upda indicate 2 person assist and trans the Rehab Director.		

AND DUAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345288	B. WING _			C 07/21/2017
NAME OF PR	ROVIDER OR SUPPLIER	1	<u>'</u>	STREET ADDRESS, CITY, STATE, ZIP COL	DE L	0.7.2.1.20.1.
				1404 S SALISBURY AVENUE		
MAGNOLI	A ESTATES SKILLED C	ARE		SPENCER, NC 28159		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 323	Continued From pag	e 54	F3	23		
	not all four (4) from n fall with injuries. Res to her head, fracture (C1 Jefferson fracture cervical vertebra (Tylto the fall. Immediate Jeopardy sling's four straps we the sling was remove caused the resident to The immediate jeopa when the facility's ac of compliance was veout of compliance at (no actual harm with minimal harm that is	chhooked only three (3) loops mechanical lift resulting in a sident # 47 had a laceration to the first cervical vertebra e) and fracture to the second pe 2 odontoid fracture) due began on 4/19/17 when the ere not all unhooked before ed from the resident. This to be pulled into the floor. In the face of the floor of		The involved staff was couns 4/20/17 by the administrator utilizing 2 staff members whe Hoyer/mechanical lift while w resident and re-inserviced or Hoyer/mechanical lift by the Director, with return demonst using a Hoyer/mechanical lift On 4/20/17 and 4/21/17 the I were trained to include full tir time staff by the therapy depathe proper use of 2 people w mechanical lifting devices with demonstration of skill. The tracontinue with all new hire sto show continued competent therapy department.	for not en using the reighing a n use of the Rehab tration of on 4/20/17. Nurse Aides me and part artment on hen using the th return aining will and annually	
	reviewing the manual has the capability to diagram in the manual loop straps. Two (2) loop straps to the both The 2 loop straps in the as 1T - 1st loop (small (middle)) or 3T- 3rd loop straps in the both to as 1B - 1st loop (smiddle) or 3B- 3rd loop indicates to attach the shoulder, to the hand	al indicates the sling has 4 loop straps on the top and 2 ttoms with 3 adjustments. the top together are referred allest) or 2T - 2st loop top (longest). Similarly the 2 ttom of the sling are referred mallest) or 2B - 2st loop top (longest). Manual also te loops nearest the patient telle bar hooks of the lift		The continued need for the n will be assessed on admission assessment by the Director of and/or Rehab Director and w reviewed quarterly with the s MDS and as needed by the use of Nurse's on the importance the care guide daily for updatunderstand the expected out resident care. Care guides at the inside of each closet doo lncidents will be brought to the clinical meeting by the Direct and a follow up review will be	on per the lift of Nurse's ill be cheduled unit manager. aff to include as ator/Director of reviewing tes and to come of the re located on r. ne daily or of Nurse's	
		er using the same length and each side. The sling leg		and a follow up review will be in the interdisciplinary weekly	•	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345288	B. WING _			C 07/21/2017	
	ROVIDER OR SUPPLIER	ARE		STREET ADDRESS, CITY, STATE, ZIP COL 1404 S SALISBURY AVENUE SPENCER, NC 28159	•	0112112011	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 323	hook of the hanger b The similar procedur. For rigid patients the the outside of the leg loop. Manual indicat lowering, when the p by the bed continue t tension of the loop, d and move the lift awa Resident was admitte with documented dia Dementia, history of osteoporosis, lack of abnormalities with ga Review of Physician 4/20/17 revealed res medication. Review of the Quarte (MDS) dated 4/10/17 5/7/14. Resident cod unclear speech and i self-understood. Res cognitively impaired. dependent and need bed mobility, transfer functional limitation is lower extremity. MDS on any pain medicati Review of the care p identification of probl assist with Activities of Potential for injury fro control. The goals in	is crossed over and to the ar located on the right side. It is followed for the right leg. It loops go straight up along and hooked on the longest less to remove the sling after atient's weight is supported to lower the lift to release the etach the sling from the lift leg from the patient. The detact the facility on 7/25/12, gnosis of Non Alzheimer's falls, Dysphagia, coordination, and lift and poly osteoarthritis. The detact the facility on 7/25/12, gnosis of Non Alzheimer's falls, Dysphagia, coordination, and lift and poly osteoarthritis. The detact from 4/1/17 through lift was not on any pain left was not on any pain left was not on any pain left was severely Resident was coded as total ling two person assist with and bathing, and having mpairment for both sides of sindicated resident was not	F3	(Patient at Risk) meeting. Fin reported by the Director of Ni monthly on an ongoing basis monthly QA Committee.	urse's		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345288	B. WING				21/2017	
	ROVIDER OR SUPPLIER A ESTATES SKILLED CA			1	STREET ADDRESS, CITY, STATE, ZIP CODE 404 S SALISBURY AVENUE SPENCER, NC 28159	1 077	21/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 323	indicate resident a tw total lift. Geri sleeves and resident to wear braces as ordered wii Utilize pillows and poindicated for assistan control. Monitor residand report to approprialls. Review of Nursing Noresident was been we (NA), when putting reonly 3 loops not all 4 moved Resident# 47 bumped her head to I Resident was sent to treatment and evalua responsible party wer Review of the inciden in part - NA was weig the resident on bed uthe lift. When NA mopulled to floor and bubed rail. Resident has due to amount of blooproperly. Pressure aphead. Physician Order date part- sent out to Eme evaluation post fall. Review of Emergency report 4/19/17 at 2:28 floor lying supine. Nu	m fall. The interventions o assist transfer with the to bilateral arms as orders orthotic and hip abduction th routine skin checks. Sitioning devices as ce with resident's poor truck ent for safety issues/ needs iate personnel to prevent of the state o	F	323				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345288	B. WING		07/21/2017	
	ROVIDER OR SUPPLIER	ARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159	, 3//2//23//	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL : LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLETION	
F 323	bed 3 feet (ft.). Neck tender spine and par hospital. Review of ER report read in part: Patient fell, sustained a lace Diagnosis: posterior cervical vertebra (typnon-displaced fractu and possible compressible admission r	on palpation due to fall from k pain on palpation and raspine. Immobilized to dated 4/19/17 at 3: 05 PM in ER, lift broke and patient eration on top of scalp. displacement of second one 2 odontoid fracture) and re of first cervical vertebra, ession of upper cervical cord. note dated 4/19/17 at 10:18 esident was admitted to	F 32	3		
	Medical Center. Hos that resident was tra EMS with a first cerv Patient was sent to home after sustainin Unknown if there wa (LOC). She fell from point of impact was to make only incomprounable to follow comnormal mental status	spital admission note indicate insferred from Hospital via vical vertebra (C1) Fracture. Inospital from her nursing g a fall from a mechanical lift. Its loss of consciousness a height of 3 to 5 ft. and the head and neck. Patient ehensible sounds and was amand. Per EMS was her is. She has a laceration to the int of impact head and neck.				
	10:46 PM read in pa hours ago. Fall occu Facility (SNF) from M height of 3 to 5 ft. an neck. Clinical impres fracture of first cervic fracture morphology.	der note dated 4/19/17 at rt- accident occurred 6- 12 rred at Skilled Nursing Mechanical lift. She fell from a rid point of impact head and ssion - Closed displaced cal vertebra, unspecified . ic Note dated 4/19/17 at rt: patient was seen at an				

	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345288	B. WING		-	l	C 24/2047	
NAME OF P	ROVIDER OR SUPPLIER	0.0200			STREET ADDRESS, CITY, STATE, ZIP CODE	071	21/2017	
	A ESTATES SKILLED CA	ARE		1	1404 S SALISBURY AVENUE SPENCER, NC 28159			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 323	first cervical vertebra vertebra fracture. Ass Recommendation ind and C2 type 2 odonto (MJ) cervical collar at (HOB) as tolerated; the of neurologic comprosessociated with surgice morbidity. Recommensurgical intervention. Review of Employee Statement dated 4/20 utilize two staff for usweighing a resident. (in-service on Mechandemonstration of use Review of the Medica 4/21/17 read in partice. (BP) remained elevath Hemodynamically states baseline mental statu MJ collar at all times. Review of nursing norpart: Resident arrived transport at 7:17 PM, neck. Resident stables signs taken. Resident stables igns taken. Resident stables igns taken. Resident arrived transport at 7:17 PM, neck. Resident stables igns taken.	fracture and second cervical ressment and icated C1 Jefferson fracture oid fracture. Maintain Miami J all times; head of bed his injury does not have risk mise, however risk cal interventions have high and no acute orthopedic. Counseling / Discipline of Mechanical lift for Corrective actions were 1) ical lift. 2) Return of Mechanical lift. Il Discharge Summary dated Resident blood pressure ed despite home regime. ble at discharge and at s. Recommended maintain to facility via facility MJ collar in place on the equation and intervenient in the back of both hands and site, respiration even and int of Bowel and Bladder, no will continue to monitor.	F	323				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345288	B. WING			C 07/21/2017	
	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 404 S SALISBURY AVENUE SPENCER, NC 28159	1 011.	21/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	PO daily for hyperten Tablets take 1 tablet I (PRN). Maintain MJ or Reviews of Physician part - Follow up after due to fall from Mechdiagnosed with a scafracture and type 2 or hospital. Orthopedic ronservative treatmerisk of high morbidity function and co-morball extremities, fingers was elevated from bapain and amlodipine I stable since return. Review of post incide 4/26/17 revealed staf IDT review for fall with administrator, activity Review of Medication (MAR) for April and Maintain medication. 4/21/17 through 4/20/1 any pain medication. 4/25/17 through 4/30/1 administered schedul tablet BID for pain. Review BID for pain.	esylate 10 MG take 1 tablet sion. Roxicodone 5 MG PO 6 hours as needed sollar at all times. notes dated 4/25/17 read in hospital observation stay anical lift. Resident lp laceration, C1 Jefferson dontoid fracture at the recommendation: In the with an MJ collar due to with surgery due to baseline idities. Resident can move and toes. Resident's BP iseline, possibility due to has started. Vital Signs Intraction report dated fre-educated on use of lift. In Social worker, director, therapy and MD. Administration Record lay 2017 revealed: 7 - resident did not receive did 2 tablet Twice a Day or pain.	F	323			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345288	B. WING		C 07/24/2047
	ROVIDER OR SUPPLIER A ESTATES SKILLED (1,1111		STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159	07/21/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 323	Continued From page	ge 60	F 32	23	
	scheduled Norco 5-	/17- resident received 325 tablet one tablet BID for lot receive any PRN Norco let BID for pain.			
	for pain at 6:00 AM,	/17 - Resident was assessed 2:00 PM, 10:00 PM. Pain was checked for maintaining s.			
	in part- expired in th	e of Death dated 5/13/17 read le facility, Probable aspiration le to Alzheimer's dementia.			
	7:05 ÅM, nurse indiresidents weights the stated NA #9 came her about Resident be before or after lu	with Nurse #2 on 7/18/17 at cated NA #9 was assigned to day of the incident. Nurse running to her and informed #47 fall, unsure of time (may nch). Nurse #2 stated when the mat #47's room, resident was			
	was lot of blood. Nu if the resident had h She indicated she d	ommate's bed frame and there rse #2 stated she was unsure it the floor or the bed frame. id not move the resident due sked the NA #9 to call the			
	supervisor while she head. Nurse #2 furth called EMS. Reside upon arrival and trai	e was applying pressure to the ner stated supervisor had nt #47 was examined by EMS nsported her to the hospital in			
	people were required lift and was unsured with the mechanical to the fall resident h would always turn to Resident #47 base	2 further stated that two (2) d when using the mechanical why NA #9 was working alone lift. Nurse #2 also stated prior ad poor neck control and to the right side. She indicated line was resident was alert d was a total assist with her			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345288	B. WING		C 07/21/2017
	ROVIDER OR SUPPLIER	CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159	07/21/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 323	ADL's. Nurse #2 fur resident had a decli was not eating well, fluids. She stated the collar placed in the landering the reside. During an interview AM, NA stated there fall because there we lift. NA #8 stated the that day but NA #9 cand used the lift with the resident hit her lander has been been been been been been been bee	ther stated that after the fall the in her medical condition, but able to consume some at the resident had a MJ mospital and this was also int comfort. with NA #8 on 7/18/17 at 9:41 was one resident that had a ras only one NA that used the at there were 4 NA on duty did not ask for help with the lift in only one person. She stated head and ended up going to with Nurse #4 on 7/18/17 at rated she was called to the ot remember the name). It NA had thought all the clips was startled by the entered the room, that is the lift, the resident was pulled the clip was left unhooked. She had assessed the Resident #47 head was ras alert and talking, laying on ween the beds. She stated ssessed by EMS and	F 323		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	COMPLETED
		345288	B. WING		C 07/21/2017
	ROVIDER OR SUPPLIER	ARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159	0772172017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 323	resident was sent to NP indicated that aft hospital, resident wapain medication, not Resident # 47 was chad decreased. NP at the time of death, death due to deterior. During an interview 11:38 AM, NA indica weights for the resident weights for the resident was placed up to be weighed and the resident was put at this time the resident was the respondent left, NA stated in, stated she respondent with the stated at this poir not reach the resident down. She stated shourse for assessment working alone with the she indicated facility did not ask for assist usually works alone weights as she was long time. She indicated feriod the pif the resident weight person.	, she was notified and the hospital for evaluation. er resident returned from the as made comfortable with overly sedated. She stated onsuming less and appetite indicated she was not present and death was a natural	F 32	23	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345288	B. WING		C 07/21/2017
	ROVIDER OR SUPPLIER	ARE	1	STREET ADDRESS, CITY, STATE, ZIP CODE 404 S SALISBURY AVENUE SPENCER, NC 28159	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 323	she was in the facilith however not witness came running and refall. DON stated whe Resident #47's head roommate's bed frar unsure why NA #9 was working alone wassistance. DON stawere 2 person assis During an interview 7/20/17 at 3:38 PM was working as the facility during the timestated on the day of him and asked him is resident to be transfindicated he was master for the resident to be the care plan indicate transfer. During an interview 07/21/2017 at 10:41 the staff should follousing 2 person for moshe further stated the transferring Resident the resident. Review of the Qualitate revealed on 4/19/17 was positioned in the and approximately 60 the came running the control of the qualitate resident.	t 12:15 PM, DON indicated by at the time of the fall soit. She indicated NA #9 eported to the nurse about the en she entered the room, It was lying against the ene. She stated she was avas distracted and why NA #9 with the lift without any ented all the lifts in the facility to the incidence his NP called for the could give orders for erred to the hospital. MD and ade aware of the incidence	F 323		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345288	B. WING		07/21/2017
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159	0112112011		
PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
F 323	the resident weights, the mattress and start that held the pad ont of the 4 hooks, the remember came into the "resident care" and the and back to the resident to the bed. NA had founclipped the 4th clip roll and fall from the move fast enough ar reach or catch the rehelp to assess the reassessed by the nursulaceration on the top head on her roommaresponsible party we reducated on the user turn demonstration were reeducated on Lift and sit to stand would attend the competency of Miduring their orientation observations will be compresent during use out lift, observations will continued quality improved the continued th	NA placed the resident on rted unhooking the 4 clips of the lift. After unhooking 3 esident's roommate family the room. NA had shouted they left the room. NA turned tent she was caring for and to pull the mechanical lift back orgotten she had not to and the resident started to bed. NA was not able to cound the mechanical lift to sident from falling. NA got tesident. Resident #47 was see and resident had a of her head from hitting her to side rails. Physician and the indicated the NA was see of the mechanical lift with the to validate skills. All NA's the use of the mechanical with return demonstration to w NA hired will be validated echanical lift and Sit to stand on period. Random completed to ensure 2 staff of Mechanical and sit to stand be ongoing to ensure provement. Indicate the facility had dents that used the care guide for the fit. No monitoring methods	F 32	3	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	' ') DATE SURVEY COMPLETED	
		345288	B. WING				21/2017	
	ROVIDER OR SUPPLIER A ESTATES SKILLED CA		<u>. I</u>	1	TREET ADDRESS, CITY, STATE, ZIP CODE 404 S SALISBURY AVENUE PENCER, NC 28159	077	21/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 323	The Administrator procredible allegation of Credible allegation of On 4/19/17 at 2:15 Pl positioned in the Hoyapproximately 6 inchethe purpose of obtain the residents weight tresident to the mattrethe 4 hooks that held unhooking 3 of the 4 room and the c.n.a. sthe visitor left the root the resident she was started to pull the me The c.n.a. had forgott the fourth hook and the fourth hook and the roll and fell from the bidistracted by the visit causing her not to unc.n.a. did not have a sthe mechanical lift be not transferring the recommon practice for resident. The conclusion of the policy the c.n.a. would while using the mechanical the facility. The secont told the first c.n.a. that	ultant, corporate vice ned of immediate jeopardy. vided an acceptable compliance on 7/21/17. Compliance: F 323 Whith resident was er lift over her bed at es above the mattress for ing her weight. After getting he c.n.a. returned the ss and started unhooking the pad onto the lift. After hooks a visitor entered the tated out "resident care" and m. The c.n.a. turned back to weighing and at this point chanical back from the bed. The that she had not undone he resident had started to bed. The c.n.a. was for coming into the room do the fourth hook. The second person to assist with cause she stated she was esident and this was her obtaining weight for this Toot cause, if following the d have had a second staff anical lift per the policy of nd staff member could have the fourth hook was still ing the mechanical lift and I the fall.	F	323				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		345288	B. WING _			C 07/21/2017
	ROVIDER OR SUPPLIER	ARE		STREET ADDRESS, CITY, STATE, ZIP C 1404 S SALISBURY AVENUE SPENCER, NC 28159	ODE	01/21/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIA	DATE
F 323	lift without unhooking resident to fall from the obtained a laceration. The physician and fa at 2:30 PM and the remergency room for observation and return with a diagnosis of C expired on 5/13/17. The involved staff was the administrator for when using the Hoyer resident and re-inser by the Rehab Director of using a Hoyer lift of using a Hoyer lift of using the mechanical demonstration of skill with new hire's and a competence. All fullting assistant were traine on 4/20/17 and 4/21/staff that have not have allowed to work until Other residents affect 7/18/17 for the need care plans and care gindicate 2 person assistents.	employee pulled the Hoyer all 4 hooks causing the ne bed hitting her head and on the top of her head. mily was notified on 4/19/17 esident was sent to the evaluation and admitted for med to the facility on 4/21/17 1 fracture. The resident as counseled on 4/20/17 by not utilizing 2 staff members or lift while weighing a viced on use of the Hoyer lift for, with return demonstration on 4/20/17. 17 the Certified Nursing ed by the therapy oper use of 2 people when I lifting devices with return I. The training will continue nnually to show continued	F	323		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345288	B. WING		07/21/2017
	ROVIDER OR SUPPLIER	ARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159	1 07/21/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLET
F 323	the incident the incident there were no other use of mechanical lift. The continued need reviewed quarterly was needed by the urron the importance or daily for updates and outcome of the residence of the residence of the inside QIO was contacted full plan of correction compliance. A QAPI completed today and scheduled at this times to the facility by was completed on-lift they will call the facility will call the facility by was completed on 7/21/1 following: 1a. On 7/18/17 at 3: Mechanical lift to assert from wheel chair to I transfer. One NA op while the other 2 asset the resident. All loops	for the mechanical lift will be with the scheduled MDS and hit manager. In the care staff was re-educated for eviewing the care guided to understand the expected lents care. Care guides are to feach closet door. In the self-assessment was an it is an it	F 32	23	
		:22 PM observed use eighing a resident laying in			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		ATE SURVEY DMPLETED
		345288	B. WING			C 07/21/2017
	ROVIDER OR SUPPLIER	CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159	<u> </u>	0772172017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	NA supported and re	ge 68 perated the lift while the other eassured the resident. Tweighed. No issues were	F 3:	23		
	on 4/20/17 and 4/21 were trained on 2 per mechanical lift and to person assist for we demonstration. Eight on the in- service ec with return demonst Occupational Thera Checklists were con proper use of gait be	rice Education report revealed /17 the facility's direct staff erson assist for the the sit to stand lift to include 2 eights; Training included return steen (18) NA's were identified ducation sheet. The in-service ration was completed by the pist. Skills Competency inpleted for the 18 NA's on elt, use of mechanical lifts, and transfer equipment.				
	PM, DON stated all re-trained by Physic properly use mecha had to demonstrate 3. Review of Employ Statement dated 4/2 counseled on 4/20/2 staff for use of mechanisms.	with DON on 7/20/17 at 12:15 direct care staff were cal Therapist (PT) on how to nical lifts. She stated the NA's their understanding skills. yee Counseling / Discipline 20/17 revealed NA #9 was 17 related to failing to utilize 2 nanical lift for weighing a Actions were 1) Employee mechanical lift. 2) Return e of mechanical lift.				
	other residents iden mechanical lift were were updated to ind staff assist or transf assist. Care Guides	are plan and Care guides of tified for the need for reviewed. The care plans icate sit to stand lift with 2 ers using total lift with 2 were updated to indicate sit aff assist or transfers using				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUCTION (X8) MULTIPLE CONSTRUCTION (X8) MULTIPLE CONSTRUCTION (X9) MULTIPLE CONSTRU		(X3) DATE SURVEY COMPLETED		
		345288	B. WING		C 07/21/2017
	ROVIDER OR SUPPLIER	ARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159	1 01/21/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 323	revealed staff were e 7/18/17 about review to understand the expresidents care. Direct locate the residents or resident closet door. 6. During an interview 7/21/17 at 11:21 AM, facility has identify the She further stated DC implement the care g the care guide that w closets. She also stat going to review the notified on 7/19/17 at visit to be scheduled. During an interview w Vice President/Direct 07/21/2017 at 11:56 discussion was held a Immediate Jeopardy of other residents with by the same deficient. The immediate jeopa when the facility's accordinance were were vereigned.	iple direct staff on 7/21/17 ducated by administrator on ing the care guide daily and bected outcome of the care staff were able to are guide inside of the with the Administrator on Administrator indicated that ose resident that use the lift. On and MDS coordinator will uide and monitor staff follow ere placed in the resident's red that rehab director was red to the lift quarterly with and as needed to keep the guides current. Ilf-assessment tool. QIO 2:30 PM. Facility waiting for with the Administrator and for of Operations on AM, they indicated that a red discuss the significance of and the expedited protection in the potential to be affected	F 32	3	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVE	ΞΥ
		345288	B. WING		07/21/20	47
	ROVIDER OR SUPPLIER A ESTATES SKILLED C			STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159	07/21/20	17
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COM	(X5) PLETION PATE
F 325 F 325 SS=D	(g) Assisted nutrition (Includes naso-gastr both percutaneous endos enteral fluids). Based comprehensive asse ensure that a resider (1) Maintains accept status, such as usua body weight range at the resident's clinical this is not possible of indicate otherwise; (3) Is offered a thera nutritional problem a orders a therapeutic This REQUIREMENT by: Based on record reviacility failed to compand implement nutrit resident with weight	and hydration. ic and gastrostomy tubes, indoscopic gastrostomy and copic jejunostomy, and d on a resident's ssment, the facility must int- able parameters of nutritional I body weight or desirable ind electrolyte balance, unless condition demonstrates that ir resident preferences	F 3.	25	etary	17
	6/9/17 and diagnose femur, iron deficience disease. A care plan for Residuate of 6/9/17 reveal	Imitted to the facility on s included fracture of the left y anemia and Alzheimer 's lent #67 with an initiation ed potential for weight loss % or more of food uneaten at		indicating a weight gain to 141.3 which is an increase, prior weigh noted, overall eating well. May se fluctuations with diagnosis of Alzl Dementia. OK with current body continue diet, and monitor weigh honor preferences. For any residents identified havir loss the RD will make recommen for either supplements, extra por	pounds, t loss ee weight heimer □s weight, t trends, ng weight dations	

OLIVILIV	OT OIT MEDIO/ ITE G	INIEDIO/ ND CEITTICE				CIVID I	10.0000 0001
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	· /	TE SURVEY MPLETED
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		345288	B. WING			0	7/21/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MAGNOLI	A ESTATES SKILLED CA	ARE			404 S SALISBURY AVENUE		
				S	PENCER, NC 28159		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 325	Continued From page		F	325			
	status. An admission minimu 6/21/17 for Resident limited, one person a	tions included for the current resident nutritional arm data set (MDS) dated #67 revealed she required ssist with eating, had not nt weight loss and had			appetite stimulants in writing to the attending physician, Director of Nurse' Dietary Manager and Administrator. The RD documents the recommendations in the reason for the recommendations in the residents chart for physicians to review.	ne and	
	weights for Resident 146.5 pounds (lbs), 6 6/28/17 - 135.8 lbs. of 10.7 lbs / 7.3% in 1 A review of the medic revealed an entry on	cal record revealed the #67 were as follows: 6/9/17 - 1/21/17 - 141.3 lbs and This reflected a weight loss 19 days. cal record for Resident #67 6/15/17 that was titled "PAR" ssion weight 146.5, weekly			The interdisciplinary Patient at Risk (P team reviewed Resident #67 s weight 8/3/17 indicating a weight gain of .2 pounds over 7 days and slight weight over 30 days. Receives a Regular diet Continue plan of care. All residents identified with nutritional assessments weight loss and interventions recommended by the RD will be review weekly in PAR meeting and changes made accordingly.	wed Resident #67 □ s weight on ating a weight gain of .2 r 7 days and slight weight gain rs. Receives a Regular diet. an of care. All residents ith nutritional assessments, and interventions led by the RD will be reviewed AR meeting and changes	
	revealed an entry on note and stated meet Manager, MDS, Ther wound. Weight was 1	edical record for Resident #67 on 6/22/17 that was titled "PAR" eeting with Administrator, Unit herapist and Activities for s 141.3 lbs, her weight was multivitamin, surgical incision is All other residents identified on nutritional assessment in the will have a nutritional assess completed by 8/18/17 by the Manager (DM) and/or RD.		The RD and the DM were in serviced of	Í		
	revealed an entry on note. Reviewed for w was 135.8 lbs showin over 7 days. Weight I episode. She is on m	cal record for Resident #67 6/29/17 that was titled "PAR" eights and post fall. Weight ag a weight loss of 5.5 lbs oss related to acute ultivitamin supplement. Diet ue to monitor weights.			8/10/17 on completing the nutritional assessment for admissions, annually, significant changes and as needed. The nutrition assessment will be completed according to the assessment reference date (ARD) to ensure timely completion.		
	Resident #67 reveale	cian orders for June 2017 for ed she was on a regular diet nutritional supplements			The MDS coordinator will post a list of assessments due on a weekly basis. The MDS coordinator will report to the	all	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ı	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345288	B. WING				C 21/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 077	21/2017
MAGNOLI	A ESTATES SKILLED CA	ARE		1404 S SALISBURY AVENUE SPENCER, NC 28159			
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 325	ordered. A review of the dietar Dietary Manger (DM) she was on a regular beverage preference food items identified or an interview on 7/19/ revealed he had just nutritional documental weeks ago. He stated Registered Dietitian (were completing the residents. He explain facility should be visit admission to obtain the ARD (assessmen MDS) date. The DM ashould be weighted whould be weighted whould loss in a week significant weight loss for nutritional interver sure what the RD 's he came 3 times per was not sure why the assessment completes he was admitted. He expected the RD to hassessment when she re-assessed her for moshe started losing we have a manual to the resident of the r	y tray card, provided by the for Resident #67 revealed diet. There were no food / s, supplements or fortified on the tray card. 17 at 11:03 am with the DM started completing the ation for residents 2 to 3 diprior to that he believed the RD) and the MDS nurse nutritional assessments for ed new admissions to the ed within 72 hours of heir food preferences and a not should be completed by the reference date for the added new admissions weekly and residents with a 2 would be considered a so and should be re-assessed and should be re-as	F	325	administrator of any nutritional assessment not completed timely. All issues of nutritional assessments not completed timely will be taken to the monthly QA committee meeting by the administrator monthly for 3 months.	ot	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	· /	(X3) DATE SURVEY COMPLETED	
		345288	B. WING _			C)7/21/2017
	ROVIDER OR SUPPLIER	ARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159		772172017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 325	requested. The MDS #67 had been review they had not added a calorie source when stated they thought F may have been relatively placement in the skill MDS nurse reported nutritional assessme Resident #67. She stexpected that a nutric completed when she A telephone interview conducted with the Rthe RD consultant for and a half and was cone day a month. He experienced turnover sometimes he had comport. He stated the facility was 6/13/17 a #67 on his list to review her name must have explained it was his cassessment would had mission and a nutrical have been added when the state of the s	dmissions to the RD if a nurse explained Resident red in the PAR meetings, but any additional supplements or she had lost weight. She Resident #67 's weight loss red to her recent surgery and red side of the facility. The she did not see that a nut had been completed for tated she would have tional assessment was was admitted. If you on 7/19/17 at 2:08 pm was reginally contracted to come added the facility had rewith the DM position and the properties of the resident red to the facility twice a related to the facility.	F3	25		
F 332 SS=D	· ·	F MEDICATION ERROR	F3	32		8/18/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345288	B. WING _		C 07/21/2017		
	ROVIDER OR SUPPLIER	CARE		STREET ADDRESS, CITY, STATE, ZIP CO 1404 S SALISBURY AVENUE SPENCER, NC 28159			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 332	that its- (1) Medication error greater; This REQUIREME by: Based on observation interviews and recommendation and medication of administering the medication. There opportunities result was evident for 1 cobserved during the findings included: 1. Resident #14 hat 12/13/16 for Toprol mouth daily for undelectronic medication the pharmacy medication of the pharmacy medica	rs. The facility must ensure or rates are not 5 percent or NT is not met as evidenced tion, staff and pharmacist ord review, the facility failed to tion error rate of less than 5% pharmacy recommendation by led release medication and by the correct dosage ordered of a	F 3		eives Toprol XL h daily *DO D3 1,000 units ay as ordered administration completed on onsultant will istration skills es and the the n physician scation labels. completed by Manager nue to		
	In an interview on stated she mistake Toprol XL because	7/19/17 at 9:30 AM, Nurse #6 inly crushed Resident #14 's she did not observe the ctronic MAR or on the card.		Results of medication admir validation will be reported to Quality Assurance committed Director of Nurses for any is identified for 3 months.	the monthly ee by the		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CO AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED			
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		345288	B. WING			07/	21/2017
	ROVIDER OR SUPPLIER A ESTATES SKILLED CA	ARE		1	TREET ADDRESS, CITY, STATE, ZIP CODE 404 S SALISBURY AVENUE SPENCER, NC 28159		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 332	Continued From page	275	F:	332			
	7/19/17 at 5:50PM an Resident #14 's exter	nded release Toprol, the xperienced a sudden drop					
	that Resident #14 dos	0/17 at 4:00 PM, the DON) stated her expectation se of Toprol XL should have led whole and not crushed.					
		a physician order dated 3 1,000 units by mouth daily.					
	during a medication p administrating a Vitan pharmacy punch card medications, mixed th	AM, Nurse #6 was observed ass. She was observed nin D3 400-unit tablet from a l. She crushed Resident #14 nem in pudding and orrect dose to Resident #14.					
	stated the physician nincreasing her dose o	9/17 at 9:30 AM, Nurse #6 nust have written an order if Vitamin D3 and she should ct dose from house stock.					
F 353 SS=D	stated her expectation the correct dose of Vi 483.35(a)(1)-(4) SUF	FICIENT 24-HR NURSING	F:	353			8/18/17
		ces e sufficient nursing staff with etencies and skills sets to					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345288	B. WING _		C 07/21/2017
	ROVIDER OR SUPPLIER A ESTATES SKILLED CA	ARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159	1 07/21/2017
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F 353	resident safety and a practicable physical, well-being of each re resident assessment and considering the r diagnoses of the faciliaccordance with the at §483.70(e). [As linked to Facility be implemented beging (Phase 2)] (a) Sufficient Staff. (a)(1) The facility musufficient numbers of of personnel on a 24-nursing care to all resident care plans: (i) Except when waive this section, licensed (ii) Other nursing persimited to nurse aides (a)(2) Except when we this section, the facilianurse to serve as a county. (a)(3) The facility musurses have the species necessary to call identified through resident in the plant described in the plant.	related services to assure ttain or maintain the highest mental, and psychosocial sident, as determined by and individual plans of care number, acuity and ity's resident population in facility assessment required Assessment, §483.70(e), will nning November 28, 2017 Set provide services by each of the following types shour basis to provide sidents in accordance with ead under paragraph (e) of nurses; and sonnel, including but not is. Faived under paragraph (e) of ty must designate a licensed harge nurse on each tour of each tour of set ensure that licensed cific competencies and skill re for residents' needs, as ident assessments, and	F 3	53	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345288	B. WING		C 07/21/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/21/2017
				1404 S SALISBURY AVENUE	
MAGNOLI	IA ESTATES SKILLED CA	ARE		SPENCER, NC 28159	
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F 353	Continued From page	e 77	F 35	3	
	resident care plans at needs.	nd responding to resident's			
	Based on observation record review, the fact sufficient nursing staft Living (ADLs) includir and nail care for 2 of reviewed for ADLs (F#33). The findings included 1. Resident #24 was current diagnoses of weakness, and deme Resident #24 had a cupdated 5/7/17 for state Activities of Daily Livit extensive assistance included for a bath/shand nail care and shatcognitively impaired at term memory impairm extensive assistance locomotion, dressing, personal hygiene and with bathing. The resiof bowel and of bladd mechanical soft diet a Nursing notes were resident was sufficient to the sufficient soft of the sufficient suffici	f to provide Activities of Daily ng the provision of showers 7 dependent residents Resident #24 and Resident : admitted on 2/18/10 with the malnutrition, muscle ntia. are plan in place last aff assistance with all ng (ADL's) and required with ADL's. Interventions hower be given as scheduled ampoo as needed. rly Minimum Data Set dated the resident was severely and had short term and long nent. The resident required		Resident #24 (Resident #27 per Stag Sample List) no longer resides in the facility. Resident #33 had a shower on 7/17/1 Consistent assignments were implemented by the Administrator and Director of Nurses on 8/1/17 to ensur continuity of care and completion of Activity of Daily Living (ADL□'s). Showill be documented on shower sheets times per week. The shower sheets where the hall nurse and signed the nurse after each shower, nail care shave is complete. Nail care will be provided by the assignurse aide during showers 2 times perweek and as needed. In the event that a shower or nail care not completed the hall nurse will be notified by the nurse aide so that the nurse can document the reason the shower and nail care was not completed 8/1/17 by Human Resources and consisted of 7 new nursing staff. 1 Registered Nurse (RN), 1 Licensed Practical Nurse (LPN), 1 Medication A (MA), 4 Nurse Aides (NA) and 2 Nurse Aides returned from Family Medical Leave.	7. de wers s 2 vill by e and der e is ted. Aide

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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				1404 S SALISBURY AVENUE			
MAGNOL	IA ESTATES SKILLED	CARE		SPENCER, NC 28159			
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F 353	Continued From pa	age 78	F3	353			
F 353	Review of the ADL revealed that the re 7/1/17, 7/2/17, 7/4/7/13/17, 7/14/17, 7 The flow sheet did bathing was given. Review of the show that the resident we showers a week or shower sheets indi 7/18/17 that the reand nail care and seview of the show resident was scheet but got a shower or care/shaving and separate was 13. There were no month of 6/2017. The resident was conducted and the in his left hand. Resident #24 finge 7/19/17 at 4:00 PM	flow sheet for July, 2017 esident received "bathing" on 17, 7/7/17, 7/11/17, 7/12/17, /15/17, 7/16/17 and 7/18/17. not indicate what kind of	F 3	A staffing meeting is condinclude the Administrator, Nurses and the staff coord. The staffing is reviewed discoordinator for the staffing shift and adjusted according scheduled day. Any nursing staff call outsite to the Director of Nurses accoordinator to assist for an eeds. The Unit Manager will man for 4 weeks, weekly round ensure that the hall nurse aides are providing ADL shower sheets are compleidentified will be reported. Risk team meeting weekly of Nurses and taken to the Assurance committee momenths for continued qualimprovement.	Director of dinator. aily by the staff g needs for each ngly for the next will be reported and/or staff ny staffing ke daily rounds ds for 4 weeks to and the nurse is and that the ete. The issues to the Patient at y by the Director e Quality nthly for 3		
	7/19/17 at 10:45 A	NA) #2 was interviewed on M. She stated that staffing was e weekends. She stated that					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	COMPLETED	
		345288	B. WING		07/21	/2017
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F 353	sometimes 1 person them with 3 NAs on nursing home. She really hard to get ex She stated that in the change residents, fup. She stated that and complete the side oral care but sor to the small things i working. She stated today on 2nd shift. It this resident got a susually give resident schedule but occas resident a total bed. Nursing Assistant # at 2:57 PM. She stated ther beford did not refuse care onto things sometimesident got showel wasn't sure of the disupposed to do nail that this morning should share the stated that "the they have so much time that nail care we resident. She also a have been complete that nail care was a stated that "all care was a stated that "all care was a stated that "all care was a stated that and care was a stated that a stated that and care was a stated that an	neduled for 4 NAs but that in would call out and that left in the day shift for the whole stated many times it was verything done for the resident. The mornings she would round, seed residents and get them she would go back around she wasn't many NAs in that this resident got showers she was not sure about how shower. She stated that they showers according to the ionally they have to give a bath if they don't have time. If was interviewed on 7/19/17 she was not sure about the resident would grab that the resident would grab she she stated that the resident would grab she she stated that the resident would grab she was nervous and forgot. If she was nervous and forgo	F 38	53		
	resident. She also a have been complete that nail care was a completed sometime enough help and it another person to recare and oral care of	added that nail care should ed this morning. She stated				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345288	B. WING _			C 07/21/2017
	ROVIDER OR SUPPLIER	ARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159		0112112011
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F 353	She stated that Residus sistance. The residus scheduled on second placed in a shower of for his shower. She saware of a time that completed for this reknows last week that If the resident was now was given a bed batt combative at times. Sthink there was enout they could. She state some small care are but they got to the morare and bathing. The staff scheduler was: The staff scheduler was: 3:34 PM. She stated challenge with keeping work at the facility. Thow many residents to staff 3 to 4 NA on and 5 to 6 on first shand they don't have appealed have days off hiring and waiting to waiting on backgrour out then she would the and if it's really short working the entire face	iewed on 7/19/17 at 3:21 PM. dent #24 required total dent's showers were dishift. The resident would be hair and they would take him stated that she was not made the showers were not sident. She stated that she at the resident had a shower. It given a shower then he had a shower then and the resident was she stated that she doesn't gh NA's but they did the best at that there were probably as the NA could not get to ajor things like incontinence was interviewed on 7/19/17 at that there has been a ng staff and getting staff to hey are staffed based on are in the building. They try third, 4 to 5 on second shift iff. They do have call outs enough staff to cover when for the process of do orientation and are not checks. If there was a call by to call to replace the staff with only 3 or 4 NA's cility then she will go upstairs	F3	353		
	third shift would also one would come in, t with 2 NA's. If there i	Nurses on second shift and call NA's to come in. If no hen they would just work s just 1 NA for the entire all an NA to come work from				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER A ESTATES SKILLED (STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159	07/21/2017
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F 353	about 2 to 3 NAs an having about 3 to 4 she hasn't had to we stated that they have last week that just is been rough the last days she doesn't the that they can't get to just the little things I stated that the NAs her if she could get stated she was doin come in but just car sometimes. NA #4 (worked secondary 17/19/17 at 4:18 PM. required total assist that sometimes the care but had never the resident was sold Tuesdays and Fridanail care one day la exact date. She stain nails because the reshe did clean them electronically for she she did clean them electronically for she that he refused can would tell the nurse nurse since he's bethat he refused care been hard for the lathat many times she showers. She stated all the showers and showers up. For examples of the showers and showers up.	Third shift has been having and second shift has been NAs per shift. She stated that bork in the last month. She is had agency nurses since tarted. The staffing has just month. She stated that many ink there is enough NA and is all the care sometime but it's ike oral care or nail care. She would come to her and ask others to come in but she ig all she could to get staff to it't get them to come in and shift) was interviewed on She stated that Resident #24 ance with ADL's. She stated resident could be resistive to refused care. She stated that heduled for showers on anys. She stated that she did st week but did not know the red that she didn't cut his esident was jerking a bit but out. They document owers, nail care and shaving. To sign the shower sheet. If a re multiple times then she is she has never had to tell the en back from at the hospital is. She stated that staffing has set few months. She stated to she would try to divide the ample, if 4 residents were wer on Tuesday then she	F 35	3	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345288	B. WING		C 07/21/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159	07/21/2017
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F 353	other 2 on Wednesd all of them on Tuesd sometimes that whe there wouldn't be er she couldn't always planned the previou times, resident were of a shower if they of the left hand were of the left hand were of both were long. The Director of Nurson 7/20/17 at 1:50 F shower sheets were should be document shower or full bed bit to the nurses and under bathing when On the shower days sign on the shower days sign on the shower Residents were supposed too. Residents were supposed to shower day. She stated that som they will forget to sign sheets. She has had	day if she wasn't able to get to day. She stated but en she comes on Wednesday hough NAs working again and get to the showers as is day. She stated that other e just given a bed bath instead couldn't get to them. She dn't say if showers were being	F 38	53	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		345288	B. WING			C 07/21/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1404 S SALISBURY AVENUE SPENCER, NC 28159		7/21/2017	
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F 353	team". She stated when the resident scheduled. She sta any shower sheets someone may hav stated that they are shift, they want 4 N trying to hire staff r be absent within the She stated that she on Tuesday from 3 that this was unus like to have 5-6 NA stated that she and start calling NAs to come in then they have. She stated to the floor. She st ups and downs with and staffing 2nd shoulding. She stated they could with stand staffing 2nd shoulding. She stated that the resident's nails on stated that the resident's nails on stated that the nursit when she could. Mursing Assistant at 1:59 PM. She stated when the stated that the nursit when she stated that the nursit when she could.	age 83 If NA that are working and "tag she was not aware of a time was not getting a shower as ated that she was unable to find a for June, 2017. She thought the thrown them out. The DON the having many call outs. On 3rd that working at night. They are now. They are not supposed to be first 90 day of being hired. The worked the medication cart with 30 PM to 5:30 PM. She stated wal. She stated that she would also on second shift and she do the staffing scheduler would be come in. If others couldn't had to just work with what they had to just work with what they had scheduler would be pulled ated that they have had their the staff as does every building hift is a challenge with any do that they are doing the best ffing and they have some good wed on 7/21/17 at 4:36 PM. He dent was given a shower on that the shower sheet was just in his shift and when he as the resident a shower on that he didn't even touch the 7/19/17 and told the nurse. He see stated that she would get to Stated that they just have too are for to get to everything.	F	353			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) PLAN OF CORRECTION (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345288	B. WING		07/21/2017
	MAGNOLIA ESTATES SKILLED CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159	VIII 1
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 353	11:25 AM. She state showers or more to land that there was owas missed or refusito be completed as a that she wanted 6 N. 2nd shift. When therentire facility, the nuthe NAs. She stated 2:00 AM and the facodor noted and theremed aide working. Swould get coverage shift will stay over urdoes not feel that pathe staffing. She stat NAs since she has be process of hiring one now. She added that responsible with the staff. 2. Resident #33 was cumulative diagnose seizures. His quarterly Minimulatiotated Resident #impairments with verificated resident #impairments w	as interviewed on 7/21/17 at d she expected that 2 be completed for residents ommunication if a shower ed. Nail care was supposed a part of a shower. She stated As on 1st shift and 5 NAs on e was only 2 NAs for the rses would make round with that one night she came in at illity was quiet, there was no e was 3 NAs, a nurse and a She stated that the scheduler if needed and sometimes 1st ntil someone comes in. She tients have been affective by ted she has replaced a few been here. They are in the e more NA for third shift right at she and the DON were hiring and interviews for new admitted on 1/22/15 with the sof anoxic brain injury and severe cognitive roal and physical behaviors. otal assistance for bathing	F 35	,	
	indicated he required assistance of two starefusal of care, aggre	vised care plan dated 5/23/17 d extensive to total aff members due to his ession and combativeness at les of daily living (ADLs). He			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF F	ROVIDER OR SUPPLIER	343200	B: ********		TREET ADDRESS, CITY, STATE, ZIP CODE	1 077	21/2017	
	IA ESTATES SKILLED CA	ARE		1	404 S SALISBURY AVENUE SPENCER, NC 28159			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 353	was care planned for bathing and approach Resident #33 was on scheduled for shower Thursday on first shift A review of the daily selectronic Bath Checl June 2017 and July 2 for Resident #33: June 2017 Review: 6/1/17 (Thursday) - n shower but received: 6/4/17 (Sunday)-show 6/5/17 (Monday)-bed: 6/8/17 (Thursday) - spore 6/12/17 (Monday) - spore 6/12/17 (Monday) - spore 6/12/17 (Monday) - spore 6/12/17 (Monday) - spore 6/12/17 (Thursday) - spore 6/12/17 (Monday) - spore 6/12/17 (Thursday) - spore 6/12/17 (Thursday) - spore 6/12/17 (Monday) - spore 6/12/17 (Thursday) - spore 6/12/17 (Thursday) - spore 6/12/17 (Monday) - spore 6/12/17 (Monday	two staff assistance when hed for refusals. the daily shower sheets as as every Monday and t. shower sheets and the k Roster for the months of 2017 indicated the following of documented bath or a bed bath 6/2/17 ever bath hed bath hoponge bath the hospital from 6/14/17 shower shower bed bath hower the ba	F	353				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
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		345288	B. WING				21/2017
	ROVIDER OR SUPPLIER A ESTATES SKILLED C	ARE	•	1	STREET ADDRESS, CITY, STATE, ZIP CODE 404 S SALISBURY AVENUE		
				S	SPENCER, NC 28159		
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 353	Resident #33 required The staff scheduler was 3:34 PM. She stated challenge with keepi work at the facility. Thow many residents to staff 3 to 4 NA on and 5 to 6 on first shand they don't have people have days off hiring and waiting to waiting on backgroun out then she would the and if it's really short working the entire facto work on 1st shift. If third shift would also one would come in, the with 2 NA's. If there if facility. They would of the assisted living. They would of the assisted living. They about 2 to 3 NAs and having about 3 to 4 N she hasn't had to wo stated that they have last week that just stopen rough the last redays she doesn't third that they can't get to just the little things lift stated that the NAs wher if she could get of stated she was doing come in but just can't sometimes. In an interview on 7/	vas an ongoing problem and ad two staff to shower him. vas interviewed on 7/19/17 at that there has been a ng staff and getting staff to hey are staffed based on are in the building. They try third, 4 to 5 on second shift iff. They do have call outs enough staff to cover when f. They are in the process of do orientation and are nd checks. If there was a call ry to call to replace the staff with only 3 or 4 NA's cility then she will go upstairs Nurses on second shift and call NA's to come in. If no then they would just work is just 1 NA for the entire call an NA to come work from third shift has been having disecond shift has been NAs per shift. She stated that rk in the last month. She had agency nurses since arted. The staffing has just month. She stated that many nk there is enough NA and all the care sometime but it's ke oral care or nail care. She would come to her and ask others to come in but she gall she could to get staff to the get them to come in	F	353			
	Assistant (NA) #4 St	ated staff document in the					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345288	B. WING		C 07/21/2017
NAME OF PROVIDER OR SUPPLIER MAGNOLIA ESTATES SKILLED CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159	, 0,,2,,,20,,,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 353	try to sign the shower many times it's not do staffing has been har they can't give all the showers as schedule times when a resident instead of a shower it to them to shower the In an interview on 7/1 stated that often their instead of showers be enough staff. In an observation on Resident #33 was set the hallway. He appeor incontinence. Ther behaviors observed. In a second observat Resident #33 was eathe appeared absent incontinence. He was weather. He was cooverbal or physical bell In an interview with N she stated she was a she did not have time today. She stated it was uncooperative today time to complete her break. NA #1 stated inability to complete hyet but she would rep	r showers. She stated they sheets when they can but boumented. She stated that direcently and many times in assigned residents d. NA #4 stated there were it was given a bed bath for they staff was unable to get em on their shift. 9/17 at 9:03 AM, NA #6 resident was given bed baths because there was not 7/19/17 at 9:50 AM, If-propelling his wheelchair in ared clean, absent of odors was no evidence of a clean and dressed for perative and absent of	F 35	53	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345288	B. WING		C 07/21/2017
	ROVIDER OR SUPPLIER A ESTATES SKILLED CA	.RE		STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159	1 01/21/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 490 SS=J	A review of Resident 5/1/17 to present incluregarding his verbal and documented refus. In an interview on 7/2 Director of Nursing (Dexpectation that Resident showers as scheduled active seizure activity expectation that Resident oday on second shift 483.70 EFFECTIVE ADMINISTRATION/R 483.70 Administration A facility must be admenables it to use its refficiently to attain or practicable physical, well-being of each restricted physical, well-being of each restricted physical, in the second shift administration leadership and manageresident's needs were reviewed for accident On 4/19/17 Resident cognitively impaired heing weighed by me person assist. The as Resident # 47 had un	#33's nursing notes from uded multiple notes ggressive and agitation but all of his ADLs. 0/17 at 4:00 PM, the OON) stated it was her dent #33 receive his d unless he was having. She stated it was also dent #33 receive a shower dent #33 receive a shower dent #33 receive a shower dent #34 receive a shower dent #35 receive a shower dent #36 receive a shower dent #36 receive a shower dent #37 receive a shower dent #38 receive a show	F 49		gers s
	fall with injuries. Res	dent # 47 had a laceration o the first cervical vertebra		facility.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI	NG _			С	
		345288	B. WING				21/2017	
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	·		
MACNOLI	A FOTATEO OVII I ED O	ADE		14	404 S SALISBURY AVENUE			
MAGNOLI	A ESTATES SKILLED C	ARE		s	PENCER, NC 28159			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 490	Continued From pag	e 89	F.	490				
	(C1 Jefferson fractur	e) and fracture to the second			Other residents with the potential to be	į		
		pe 2 odontoid fracture) due			affected were re-assessed on 7/18/17			
		# 47 expired on 5/13/17			the need for the mechanical lift and the	<u>;</u>		
		·			care plans and care guides were upda	ted		
	Immediate Jeopardy	began on 4/19/17 when the			to indicate 2 person assist/transfer by	.he		
	sling's four straps we	ere not all unhooked before			Rehab Director.			
	the sling was remove	ed from the resident. This						
	caused the resident t	to be pulled onto the floor.			The continued need for the mechanica	l lift		
	The immediate jeopa	ardy was removed on 7/21/17			will be assessed on admission per the	lift		
		e facility's acceptable			assessment by the Director of Nurse's			
		compliance was verified.			and/or Rehab Director and will be			
	-	in out of compliance at a			reviewed quarterly with the scheduled			
		evel D (no actual harm with			MDS and as needed by the unit manag	jer.		
	·	an minimal harm that is not						
		to allow the facility time for			On 7/18/17 the direct care staff was			
	to implement full plar	n of corrections.			re-educated by the administrator/Direc			
					of Nurse's on the importance of review	-		
	Findings included:				the care guide daily for updates and to			
	This ton is successful	and to			understand the expected outcome of the			
	This tag is cross refe	erred to.			resident care. Care guides are located the inside of each closet door.	OH		
	1 E323 Based on	observations, Physician and			the inside of each closet door.			
		records review the facility			Incidents will be brought to the daily			
	failed to prevent an a				clinical meeting by the Director of Nurs	Δ' ς		
	mechanical lift result				a follow up review will be completed in			
	residents reviewed for				interdisciplinary weekly PAR (Patient a			
	[Resident # 47].	or decidente and raile			Risk) meeting. Findings will be reporte			
	[. (00.00				by the Director of Nurse's monthly on a			
	2. F224 - Based on c	observations, interview with			ongoing basis at the monthly QA			
		n and Administrator and			Committee.			
		icility failed to prevent an						
		echanical lift resulting in			On 7/19/17 the Quality Improvement			
		ents reviewed for accidents			Organization (QIO) was contacted for			
	and falls [Resident #				assistance to achieve and maintain compliance.			
	On 7/18/17 at 2:30 A	M the administrator,			·			
	corporate nurse cons			A QIO visit was conducted on 7/31/17	to			
		ned of immediate jeopardy.			include the QIO Quality Advisor,			
	·	ovided an accentable			Administrator DON and MDS coording	tor		

Facility ID: 953465

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345288	B. WING			1	C 21/2017	
NAME OF P	ROVIDER OR SUPPLIER	2.1221	<u> </u>	-	TREET ADDRESS, CITY, STATE, ZIP CODE	1 077	21/2017	
TVAIVIL OF T	TOVIDER OR OUT FIER				404 S SALISBURY AVENUE			
MAGNOLI	A ESTATES SKILLED C	ARE						
				-	SPENCER, NC 28159			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 490	Continued From page	e 90	F4	490				
	credible allegation of	compliance on 7/21/17.						
	Allegation of Complia	·			All other residents as having the poten to be affected by the use of the mechanical lift had their transfer status			
	On 4/19/17 at 2:15 P				re-assessed by the DON and MDS			
	positioned in the Hoy				coordinator on 7/18/17 for the need for	the		
		es above the mattress for			mechanical lift.			
		ing her weight. After getting			Care plane and care guides were unde	ato d		
		the c.n.a. returned the ess and started unhooking			Care plans and care guides were updated by the MDS coordinator to indicate 2	ilea		
		the pad onto the lift. After			person assist and transfer for those			
		hooks a visitor entered the			requiring the mechanical lift.			
	_	tated out "resident care" and			Toquing the modulation into			
		m. The c.n.a. turned back to			On 4/20/17 and 4/21/17 the nurse aide	es to		
	the resident she was	weighing and at this point			include full time and part time staff were			
	started to pull the me	chanical lift back from the			re-educated on the use of the mechani	ical		
	bed. The c.n.a. had for	orgotten that she had not			lift and skills observations completed b	y		
		ok and the resident had			the Rehab Director.			
		from the bed. The c.n.a.						
	_	visitor coming into the room			The nurse aides will be trained by the			
		do the fourth hook. The			therapy department on the use of the			
		second person to assist with cause she stated she was			lifting device upon hire and annually to			
		esident and this was her			show continued competency on the lift device.	ing		
	_	obtaining weight for this			device.			
	resident.	obtaining weight for this			The direct care staff to include full time	1		
	rootaont.				and part time staff was re-educated by			
	The conclusion of the	e root cause, if following the			administrator on 7/18/17 on the			
		d have had a second staff			importance of reviewing the care guide	;		
	while using the mech	anical lift per the policy of			daily for updates and to understand the	Э		
		nd staff member could have			expected outcome of the residents car			
		at the fourth hook was still			Staff were not permitted to work until the			
	-	ing the mechanical lift and			in-service was completed. Care guides			
	could have prevented	the fall.			each resident are located on the inside	of		
	0-44047 1045	NA sodelle elektristes (C			their closet door.			
		M while obtaining the			Linea bire the direct care staff will be			
	_	employee pulled the Hoyer			Upon hire the direct care staff will be	d/or		
		all 4 hooks causing the ne bed hitting her head and			educated by the Director of Nurses and Unit Manager on care guides, its purpo			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION		DATE SURVEY COMPLETED
		345288	B. WING			C 07/21/2017
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		01/21/2017
				1404 S SALISBURY AVENUE		
MAGNOLI	A ESTATES SKILLED CA	ARE		SPENCER, NC 28159		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AR	HOULD BE	(X5) COMPLETION DATE
				DEFICIENCY)		
F 490	Continued From page		F 49			
	The physician and fa	on the top of her head. mily was notified on 4/19/17		and their location.		
		esident was sent to the		On 7/19/17 in-services began for		
		evaluation and admitted for		in all departments and they were	9	
		ned to the facility on 4/21/17		re-educated on the facility □s	-!-!-44	
		1 fracture. The resident		abuse/neglect policy by the adm and Director of Nurse's and the		
	5/13/17.	atory complications on		included to follow the care plan		
	5/15/17.			guide for each individual resider		
	On 4/20/17 and 4/21/	17 the Certified Nursing		completed on 7/24/17. Staff wei		
	Assistants were train	•		permitted to work until the in-se		
		oper use of 2 people when		were complete.		
		lifting devices with return		, , , , , , , , , , , , , , , , , , ,		
		. The training will continue		A 24 hour initial report was com	pleted by	
		nnually to show continued		the administrator and sent to No		
	competence. All full-t	ime certified nursing		Carolina Division of Health and	Human	
	assistants were trained	ed by the therapy		Service/Health Care Personnel		
	department on 4/20/1	7 and 4/21/17, there are 2		Investigation on 7/20/17.		
	per diem staff that ha	ve not had the training and				
	will not be allowed to	work until training is		A 5 day report was completed 7	/26/17 and	
	completed.			sent to North Carolina Division		
				and Human Service/Health Care	9	
	•	y meeting with department		Personnel Investigation by the		
	•	rnoon of 07/17/17 the		administrator (HCPI).		
		perations re-inserviced the		T	5 0/0/47	
		partment Managers on the		The HCPI has a scheduled visit	for 8/9/17	
	· ·	and Neglect policy. On		for their investigation.		
		of Operations and the		Linear any remarks of above / read	4 41	
		perations met with the		Upon any reports of abuse/negl administrator/Director of Nurse's		
		w the significance of an				
		situation and the expedited ity residents. The Director of		report any allegations to HCPI v hour/24 hour time frame.	num me 2	
	•	Director of Clinical Operations		Any reportable allegations will b	.0	
	•	•		reviewed by the V.P. of	C	
	will continue to monitor the facility's adherence to corporate policies and regulated guidelines with			Operations/Regional Nurse Cor	sultant	
		a regulated guidelines with a sand weekly on-site visits.		and in addition the reports will b		
	dany conference can	and weekly on site visits.		reviewed in monthly Quality Ass		
	On 7/18/17 the Direct	tor of Operations initiated		(QA) Committee for 3 months at		
		Il Magnolia Estates C.N.A.'s		quarterly Executive QA Commit		

Facility ID: 953465

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345288	B. WING _			1	C 21/2017
	ROVIDER OR SUPPLIER A ESTATES SKILLED CA	ARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159			1 017	21/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 490	Continued From page regarding the policy for lift requiring 2 staff to correctly. Other residents with the by this deficient pract 7/18/17 for the need of the care plans and call indicate 2 person asson Rehab Director. The continued need for reviewed quarterly with as needed. On 7/18/17 the direct by the Administrator of reviewing the care guarderstand the experience inside of each closet. On 07/20/17, the Direct inserviced the Administrator of the presidents care.	or the use of the mechanical operate and use the lift the potential to be affected ice were re-assessed on for the mechanical lift and are guides were updated to list and transfer by the for the mechanical lift will be the scheduled MDS and the importance of lide daily for updates and to care staff was re-educated on the importance of lide daily for updates and to care of lide daily for updates and to care staff was re-educated on the importance of lide daily for updates and to care staff was re-educated on the guides are located on the door.	F 4	490		ALE	
	and directing the facilin accordance with the policies. Several metathis are Quality Assur Improvement commit Director, Social Work Medical Records Director Housekeeping Super related to quality assurativities as needed a implementing appropidentified facility conditions.	implementing, evaluating, lity's programs and activities e corporation's established thods used to accomplish rance and Performance tees involving the Medical er, DON, Pharmacist, ector, Dietary Manager and visor to identify issues essment and assurance and developing and riate plans of action for terns. In addition, quarterly are sent to Responsible					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345288	B. WING _			C 07/21/2017	
	ROVIDER OR SUPPLIER A ESTATES SKILLED CA	ARE		STREET ADDRESS, CITY, STATE, 2 1404 S SALISBURY AVENUE SPENCER, NC 28159	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTIVE CROSS-REFERENCED			
F 490	presented to QA and policies and procedur Administrator has an allows all residents, woice concerns at any The charge nurse will ensure that the care deviation from the cacare guides will be reinvestigated for possicorporation's progress employees violating or regulatory guidelines including discharge be Department Manager QIO was contacted 7 full plan of correction compliance. A QAPI assigned to the facility self-assessment, the call the facility to school Verification of Credible 1. When were you lass Neglect Policy? What related to neglect? During an interview we 9:00 AM, Nurse # 3 sabuse/neglect yester would report neglect.	s, the results of which are modifications made to res as required. The open door policy which risitors, and staff members to y time. I monitor the C.N.A.s to guides are followed. Any re provided according to the ported to the DON to be ble neglect. As part of the sive disciplinary process, corporate policy and/or will be counseled up to and y the appropriate rand Administrator. I/19/17 for assistance with a to achieve and maintain self-assessment was 17 and returned to the QIO y. After reviewing the QIO indicated they would edule their first visit.	F	490			
		he underwent abuse and					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345288	B. WING		C 07/21/2017	
	ROVIDER OR SUPPLIER A ESTATES SKILLED O	ARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION	
F 490	report it and indicate and the steps to take and the steps to take During an interview AM, NA stated She Abuse and Neglect. report to the nurse a would take. During an interview 9:31 AM, she stated on Abuse and Neglect was when s for the resident. During an interview 9:39 AM, NA indicat Abuse and Neglect. resident being abuse resident and would in During an interview 7/21/17 at 11:15 AM was in serviced this She stated Neglect abuse. She further stated Neglect abuse. She further stated in gresident una During an interview therapist assistant (AM, COTA stated she neglect 7/20/17. She report abuse/neglect	with NA #16 on 7/21/17 at she was in-service yesterday ct. She further stated that omeone doesn't provide care with NA #16 on 7/21/17 at she was in-service yesterday ct. She further stated that omeone doesn't provide care with NA #16 on 7/21/17 at she was in-service yesterday ct. She further stated that omeone doesn't provide care with NA #16 on 7/21/17 at she was trained in She stated, if she saw a sed, she would not leave the notify the nurse. with MDS coordinator on , MDS Coordinator stated she past week on abuse/neglect. was one of the 5 forms of tated Neglect would be not t was on the care plan and	F 49			
	2. How will you mon with Policies and Re	itor the facility's adherence gulations?				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	COMPLETED
		345288	B. WING		C 07/21/2017
	ROVIDER OR SUPPLIER	ARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159	VIII 11 11 11 11 11 11 1
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDE DEFICIENCY)	D BE COMPLETION
F 490	Continued From pag	e 95	F 49	0	
	of Operations on 07/ stated that he and co facility's adherence of them will be in bui 3. When were you la using mechanical lift required to use the li During an interview 9:00 AM, Nurse # 3 s required to use the li will monitor staff by g and checking for 2 p During an interview of 9:05 AM, NA stated s using the lift. She stated further stated that sh guide and care plant resident's care guide resident's closet. During an interviewe 9:19 AM. She stated about the lift and that su using a lift. She also resident's closets for During an interview of AM. She stated that use the lift. She stated	st trained on the policy of s? How many staff are ft? with Nurse #3 on 7/12/17 at stated that 2 people were ft. She also stated that she poing into the resident's room eople using the lift. with NA #15 on 7/21/17 at 2 people are needed when sted she was in serviced and once since then. She e was also educated on care She stated that the were located in the d with NA #2 on 7/21/17 at that she underwent training eeks ago on how to properly 2 people are required when indicated care guide were in			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		(X3) DATE SURVEY COMPLETED
		345288	B. WING		C 07/21/2017
NAME OF PROVIDER OR SUPPLIER MAGNOLIA ESTATES SKILLED CARE STREET ADDRESS, CITY 1404 S SALISBURY AV SPENCER, NC 2815 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH COF				TREET ADDRESS, CITY, STATE, ZIP CODE 404 S SALISBURY AVENUE SPENCER, NC 28159	1 01/21/2011
PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 490	During an interview 9:39 AM, NA indicat peoples to use the I educated on this. SI on the resident clos provide care for resident clos provide care for resident educated on the week. She further educated on care guide. 4. How will you more are being followed: from the care guide. During an interview 9:00 AM, Nurse #3: communicate any of the NA. She further follow the care guide. During an interview 9:31 AM, she stated sheets, and do obset that she would cour missed a care or not sheets. 5. Are Care plans and with lifts updated? On 7/21/17 the care residents identified the were reviewed. The indicate sit to stand transfers using total were updated to indicate in the care updated to indicate sit uses the care updated to up	with NA #16 on 7/21/17 at ed that they have to have 2 fft no matter what and was ne further stated care guide et doors indicated how to dents. with NA #5 on 7/ 21/17 at she was in serviced early in er stated that she was also uide and care plan. itor NA's that the care guides What if there is a deviation What do you do? with Nurse #3 on 7/12/17 at stated she would nanges to the care guide to stated that if NA did not e, she would counsel the aide. with Nurse #5 on 7/21/17 at she would checks shower ervation of care. She stated sel the NA if they have	F 490		

(X1) PROVIDER/SUPPLIER/CLIA

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(X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345288	B. WING			С	
NAME OF D		343200	B. WING _	CTREET ADDRESS CITY STATE ZID COL		07/21/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	Œ		
MAGNOLI	A ESTATES SKILLED CA	ARE		1404 S SALISBURY AVENUE			
			SPENCER, NC 28159				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 514 SS=D	notified on 7/19/17 at visit to be scheduled. During an interview w Vice President/Direct 07/21/2017 at 11:56 / discussion was held to Immediate Jeopardy of other residents with by the same deficient. The immediate jeopa when the facility's accord compliance were w remain out of compliance severity. 483.70(i)(1)(5) RES RECORDS-COMPLE LE (i) Medical records. (1) In accordance with standards and practice.	elf-assessment tool. QIO 2:30 PM. Facility waiting for with the Administrator and or of Operations on AM, they indicated that a o discuss the significance of and the expedited protection in the potential to be affected is practice. Try was removed on 7/21/17 ceptable credible allegation erified. The facility will ance at a lesser scope and ETE/ACCURATE/ACCESSIB The accepted professional ces, the facility must ords on each resident that ented; e; and ganized	F 5			8/18/17	

PRINTED: 09/01/2017 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345288	B. WING			07/	21/2017
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 011.	21/2017
MAGNOLI	A ESTATES SKILLED CA	\RF	1404 S SALISBURY AVENU		404 S SALISBURY AVENUE		
			5	SPENCER, NC 28159			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 514	Continued From page	e 98	F	514			
	• •	on to identify the resident;					
	(ii) A record of the res	sident's assessments;					
	(iii) The comprehensing provided;	ve plan of care and services					
	(iv) The results of any and resident review e determinations condu						
	(v) Physician's, nurse professional's progres	e's, and other licensed ss notes; and					
	(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced						
	record review, the factorized accuracy of a treatmet (TAR) indicating a uring provided when it not contact the second accuracy of the sec	ent administration record nary catheter change was done as ordered for 1 esidents reviewed for urinary			Resident #20 had his urinary catheter changed on 7/19/17, it was documente in the nurse s notes accordingly. There are no other residents in the faci with urinary catheters. An in-service will be completed by 8/18	lity	
	cumulative diagnoses	mitted on 11/22/16 with s of Parkinson 's Disease, ease, urinary retention, and t infections.			by the Director of Nurses/Regional Nur Consultant on accurate and complete documentation for Nurse #6. All other nurses/medication aides will b in-serviced by the Director of		
	A review of Resident physician orders date changed the 17th of e	d 5/21/17 read was to be			Nurses/Regional Nurse Consultant on accurate and complete documentation 8/18/17.	by	
	Minimum Data Set da Brief Interview for Me	#20 significant change ated 6/8/17 indicated his ntal Status (BIMS) of 2 hitive impairment with no			Nurse s documentation will be reviewed on American Health Tech (AHT) by the Director of Nurses/Unit Manager on a daily basis. Any inaccuracy s in		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345288	B. WING			C 7/ 21/2017		
	ROVIDER OR SUPPLIER	ARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 514	(ADLs) and coded as The Care Area Asses catheter referred rea A review of Resident 6/8/17 read the follow *Resident #20 had a urinary retention and #20 had a history cattempts to stand or assistance with his cemptying. He had a history in the review of Resident indicated his urinary 6/17/17. A review of Resident his urinary catheter with the review of Resident his urinary catheter with an observation and 9:30 AM, NA #2 state facility for one year a Resident #20. During	boded for extensive activities of daily living a having a urinary catheter. Seement for his urinary der to his care plan. #20 's care plan dated ving problem: urinary catheter due to prostate cancer. Resident of stretching his tubing in move about. He needed staff atheter care and urinary bag history of frequent UTI 's. d: as ordered #20 's June 2017 TAR catheter was changed on #20 's July 2017 TAR read was changed on 7/17/17. dinterview on 07/19/17 at ed she had worked at the nd she was assigned an observation of Resident	F 514		dressed ection. vill be taken nittee by the			
	#20 's catheter care, she cleaned around his urethra and cleaning his tubing. She did not attempt to clean the entirety of his penis. NA #2 was asked to further reveal his penis by pushing back his testicles and foreskin. Observed was a penile tear extending from the urethra down the underside of the shaft of his penis measuring approximately 2 inches in length. NA #2 stated his penis was not like that when he was admitted in November 2016.							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUIL		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		345288	B. WING _			07/	21/2017
	ROVIDER OR SUPPLIER	ARE		STREET ADDRESS, CITY, STAT 1404 S SALISBURY AVENUE SPENCER, NC 28159		1 0111	2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	X (EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BI ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 514	confirmed she looked daily. She stated she on his admission but today. Nurse #2 state monthly on night shift have been reported whis catheter change. In an interview on 07. #3 stated she worked observed his penis in stated the other nurse changed his urinary or Resident #20's cath changed by the other third shift. In a telephone intervin Nurse #6 confirmed sworked third shift on changed Resident #20 past but not recently, she documented on hurinary catheter Mone #6 stated she did not 07/17/17 as documented on explanation as to TAR that she change	de 100 /19/17 at 9:50 AM, Nurse #2 I at Resident #20 ' s penis thought he had a small tear it did not look like it did ad his catheter was changed at and the penile tear should when it was observed during /19/17 at 10:50 AM, Nurse I third shift but she had not a probably a month. She as who worked nights usually catheter. She confirmed eter was documented an inight nurse on 7/17/17 on ew on 07/19/17 at 3:10 PM, she worked nights and //17/17. She stated she had //0 ' s urinary catheter in the Nurse #6 was reminded his TAR she changed his day night on 07/17/17. Nurse change his catheter on nted. She was unable to offer why she initialed off on the d Resident #20 ' s urinary erview, she stated she did	F	514			
	not. She stated she surinary catheter a moobserved pus and bloom noted the penile tear. In an interview on 7/1 stated it was her first	thought she changed his onth or so ago and had ood at his urethra but had not					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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		345288	B. WING _			07/	21/2017
NAME OF PROVIDER OR SUPPLIER MAGNOLIA ESTATES SKILLED CA		ARE		14	TREET ADDRESS, CITY, STATE, ZIP CODE 104 S SALISBURY AVENUE PENCER, NC 28159		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 520 SS=G	were observed assess The DON pulled back and testicles to revea stated "it wasn ' t like DON stated she was worsened since she la ago". In a nursing note date read Resident #20 ' s changed without diffice the staff, at least one of wadministrator, owner, individual in a leaders.	Jursing (DON) and NA #14 sing Resident #20 's penis. Resident #20 's foreskin I the penile tear. NA #14 that 3 months ago". The unable to recall if it had ast observed it a "few weeks and 7/19/17 at 4:59 PM which urinary catheter was sulty. 21/ at 10:40 AM, the her expectation that if the her expectation that if the her changed Resident #20 's 17/17, she would have hatheter change. (i)(ii)(h)(i) QAA ERS/MEET Int and assurance. Intain a quality assessment ittee consisting at a sing services; for or his/her designee; for members of the facility's for must be the a board member or other		514			8/11/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345288	B. WING			C 7/21/2017		
NAME OF PROVIDER OR SUPPLIER MAGNOLIA ESTATES SKILLED CARE				STREET ADDRESS, CITY, STATE, ZIP COD 1404 S SALISBURY AVENUE SPENCER, NC 28159		7/21/2017		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 520	coordinate and evaluate identifying issues with assessment and assinecessary; and (ii) Develop and implication to correct identifying issues with action to correct identifying issues of info. Secretary may not respect to the secretary may not respect to the such committee with section. (i) Sanctions. Good for committee to identifying deficiencies will not be sanctions. This REQUIREMENT by: Based on observation record review the fact and Assurance (QAA maintain implemente the interventions that in June, 2016 following and subsequently recourrent recertification. The recited deficiency notification of changes	terly and as needed to ate activities such as a respect to which quality urance activities are ement appropriate plans of tified quality deficiencies; rmation. A State or the quire disclosure of the mittee except in so far as ated to the compliance of the requirements of this aith attempts by the and correct quality are used as a basis for I is not met as evidenced one staff interviews, and ility's Quality Assessment and Committee failed to deprocedures and monitor the committee put into place and a recertification survey cited in July 2017 on the and complaint survey. Sies were in the area of a (F157) and provide	F 5:	The facility's Quality Assuran Committee failed to implemer and revise as needed the acti developed for the recertificatic dated June 2016 in order to a sustain compliance. All residents residing in the fa the potential to be affected. On 7/20/17 the V.P of Operat in-serviced the department marelated to the appropriate fund	nt, monitor ion plan on survey ichieve and icility have ions anagers ctioning of			
	continued failure of the surveys of record sho	the care plan (282). The ne facility during two federal ow a pattern of the facility's effective Quality Assurance		the monthly QA Committee (A DON/Infection Control, MDS I Maintenance Director, Dietary Social Worker, Medical Recor	nurse, / Manager,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345288	B. WING			l '	04/0047
	ROVIDER OR SUPPLIER			s 1	STREET ADDRESS, CITY, STATE, ZIP CODE 404 S SALISBURY AVENUE SPENCER, NC 28159	U112	21/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 520	failed to notify the phy condition of a urinary (urethra) for 1 (Reside reviewed for urinary of F282-Based on observed review, the fact planned intervention for catheter to prevent in reviewed for urinary of The Administrator was 11:21 AM. She stated monthly. Her expecta committee to meets in concern, do a root catheter and a unitary of the stated monthly.	d: renced to ervations, staff and and record review, the facility ysician for a change in catheter insertion site ent #20) of 1 residents catheters. rvation, staff interview and cility failed to ensure a care for securing a urinary jury for 1 of (Resident #20) 1 catheters. s interviewed on 7/21/17 at d that the QA committee met ation was for the QA monthly and identify areas of use analysis and develop a nd monitor that plan and	F	520	Housekeeping, Admissions Director, st nurse and nursing assistant) and the purpose of the committee to include identifying issues related to quality assessment and assurance activities a needed and developing and implement appropriate plans of action for identified facility concerns. Findings and results of the QI tool with reviewed by the monthly QI committee and the quarterly Executive QA Committee will review trends, corrective actions taken and the dates of completed The QA committee will develop and implement appropriate plans of action to correct and identify quality deficiencies include accidents, care plans, neglect, administration and QA. The quarterly Executive QA Committee include the Medical Director and Pharmacy consultant, and all members the QA committee will validate the facility's progress in correction of deficit practices or identified concerns. The quarterly Executive QA Committee meeting agenda, resulting plans of correction, and audit results will be documented in the meeting minutes. The administrator will be responsible for ensuring QA Committee concerns and recommendations are addressed through further training or other interventions. The administrator or DON will report back to the Executive QA Committee at the new quarterly meeting.	es ing de la	