STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	C 04/17/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The original Recertification/Complaint Survey was conducted from April 9-12, 2012. Based upon information obtained from one of the complainants, the survey exit date was extended and the additional information was surveyed on April 17, 2012.	F 000	Magnolia Lane of Morganton acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality care of the residents. The Plan of Correction is submitted as a written allegation of compliance. Magnolia Lane's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that the deficiency is accurate. Further, Magnolia Lane reserves the right to submit documentation to refute any of the stated deficiencies on	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, family and staff interviews, and record reviews the facility failed to provide in room activities for one of one sampled residents. (Resident #60) The findings are: Resident # 60 was readmitted to the facility with diagnoses including persistent vegetative state, quadriplegia, traumatic brain injury and seizure disorder. A review of the activity progress note, dated 07/29/11 revealed resident # 60 had identified past interest of cars, games, sports, likes listening to music (country and Rock'n roll) and movies and TV. Review of the most recent activity progress note	F 248		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jean Carter Lr LNHA | TITLE: Administrator | (X6) DATE: 5-11-12

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.

Original Signature Date: 5-7-12

RECEIVED
MAY 15 2012
Facility ID: [illegible]
BY: _____

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F 248	Continued From page 1 dated 10/19/11 indicated the resident was confined to his room and that in-room activities/ projects were provided in keeping with life long and current interest. Review of the narrative note section of that report specified, "Activity staff do provide in room visits for stimulation and socialization. Resident does not verbally respond but at times tracks with his eyes. Activity staff will continue to provide in room visits at this time." The quarterly Minimum data Set (MDS) dated 01/18/12 revealed Resident # 60 had been assessed to require maximum assistance of two persons for activities of daily living. This assessment further indicated that Resident # 60 was unable to communicate his needs due to his persistent vegetative state. The current care plan, which was last updated on 02/02/12, indicated the goal for Resident # 60 was to receive routine tactile and auditory stimulation through next review. The care plan further specified interventions to provide a stimulation program such as turning the TV on routinely. Review of the "activities programming" report on 4/12/12 revealed no documentation since 02/25/12 of any one on one socialization, stimulation activities or any tactile stimulation being performed. Observations of Resident # 60 on 04/09/12 at 10:30 AM, revealed Resident # 60 lying in bed with the TV turned on but the volume was too low to be heard. The resident was on his side, unable to see TV.	F 248	this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or legal proceedings. F 248 Resident #60's care plan was reviewed and adjusted to meet his needs. Resident #60 is receiving 1 tactile stimulation/wk. and 1 auditory stimulation / wk. Re-education with activity director was done on 4-27-12. In-service was done with staff on activity preferences and also on appropriate sound levels for TV and radio on 4-27-12. Activity director did an audit of all in room resident's care plan goals. Activities were adjusted to	

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F 248	Continued From page 2 Observations on 04/10/12 at 11:15 AM revealed Resident # 60 lying in bed, head of bed slightly elevated. The TV was turned on but the volume was turned down so low it could not be heard over the medical equipment in room. During an interview with the Activities Director (AD) on 4/11/12 at 1:25 PM, he indicated he tried to keep music for Resident # 60 playing on laptops, sometimes on the AD's phone, and activities staff have tried reading to him. AD further indicated all activity treatments were tracked in computerized medical record once completed. AD indicated activities are being done routinely but maybe not being charted appropriately. AD could not be specific regarding how often he visited Resident # 60, when the last time he visited and what he did for Resident # 60. An interview with Licensed Nurse (LN) # 1 on 04/11/12 at 3:00PM revealed she was not aware of other planned/scheduled activities for Resident # 60 except TV. LN # 1 stated the family visited and sometimes planted flowers outside the resident's window, and once he had a roommate that talked to him at times. The Administrator of the facility was interviewed on 04/12/12 at 2:35PM regarding her expectations of AD. The administrator stated the AD was expected to plan activities and make sure all residents in the building were involved, and make sure that documentation was completed. She further stated the AD needed to offer a variety of activities geared to the residents' identified preferences. Observations on 04/12/12 at 2:45 PM revealed	F 248	make certain that residents were receiving the activity of their interests and according to their plan of care. Activity Director will ensure that each resident receives the activities planned. Nursing will help to ensure that TV, radios, etc. are at appropriate sound level. QI nurse and/or administrative nurse will audit in room activities of 10 residents weekly x 4, then monthly x 3. Results will be reported to the monthly QI committee for follow-up and/or continued monitoring.	5-7-12

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F 248	Continued From page 3 Resident # 60 was in his room in his specialty chair, the television was on but channel was not set on programming marked by assessment to meet his preferences.	F 248		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to administer medications as ordered for two (2) of eleven (11) sampled residents. Residents #58 and #64. The findings are: 1. Resident #64 was admitted to the facility on 1/5/12. Her diagnoses included allergic rhinitis. On 3/30/12 a physician's telephone order included: *Zyrtec 10mg every day for ten (10) days for allergies; and *Cortisporin otiz (ear) drops two (2) drops each ear two times per day for five (5) days. Review of the Medication Administration Records (MAR) revealed both of these medications were administered as ordered on 3/31/12. Review of the April 2012 MAR revealed neither the Zyrtec nor the Cortisporin were written on the April MAR and there was no documentation that either medication was administered as ordered in April 2012.	F 281	F281 Resident #64's MARS were immediately corrected. An audit was conducted on all MARs including resident #58 by 4-30-12 by administrative nurses for accuracy. A system was put in place to double check that all new orders are transcribed to the new MAR at the beginning of the month. All copies of orders will be routed to the QI nurse daily, who will double check for accuracy of transcription. A copy of all	

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F 281	Continued From page 4 On 4/1212 at 11:02 AM Licensed Nurse (LN) # 3 stated that when the order was taken at the end of March, the new orders should have been written on the April MARs. She further stated someone was supposed to check each MAR at the beginning of the month to ensure all the medication orders were correct on the new month's MAR. On 4/12/12 at 11:07 AM an interview with the Director of Nurses (DON) revealed the nurse taking the 3/30/12 orders for Zyrtec and Cortisporin should have put the medications on the April MAR and included the stop dates to ensure the medications were administered for the time frame ordered. The DON further stated there was a first check of MARs about 4 days prior to the end of the month and then a second check by administrative nurses. This second check sometimes occurred on the same day as the first check. The DON stated there was not a check system at the beginning of the new month to ensure last minute orders were transcribed correctly. On 4/12/12 at 11:23 AM a telephone call to LN #4, the nurse who took the 3/30/12 orders for Zyrtec and Cortisporin, revealed she took the order, transcribed it to the March 2012 MAR and faxed it to the pharmacy. If the April 2012 MARs were available she would have updated it with the new orders. She further stated the April MARs were not available and she expected someone else to check the April MAR for accuracy. 2. Resident #58's diagnoses included pneumonia, hypertension, edema and chronic	F 281	new orders written after the MARs are checked will be placed in a bag provided and will be double checked by the administrative nurses for accuracy. In-service on system changes and MAR accuracy including the nurses' role in the process was conducted with nurses on 5-3-12. QI nurse and/or administrative nurse will conduct audit of 15% of charts monthly x 3. Results will be reported to the monthly QI committee for follow-up and/or continued monitoring.	5-7-12

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F 281	Continued From page 5 airway obstruction. Physician telephone orders for March 2012 revealed on 3/6/12 Lasix was decreased to 10mg per day. Another telephone order dated 3/14/12 discontinued the Lasix. Review of the Medication Administration Record for March 2012 revealed Lasix 10mg per day continued to be administered from 3/14/12 through 3/23/12. A handwritten notation on the MAR noted the Lasix was discontinued on 3/14/12. On 4/11/12 at 11:27 AM, the Director of Nurses (DON) stated the Lasix was administered incorrectly due to a transcription error. The Lasix should have been discontinued on 3/14/12 but was not changed on the MAR until 3/23/12. On 4/11/12 at 11:34 AM, an interview was conducted with the Licensed Nurse (LN) #5 who noted the order for the discontinuation of Lasix on 3/14/12. LN #5 stated the order was written by the Physician's Assistant and she (LN #5) was helping the nurses on the floor by faxing the order to pharmacy. LN #5 stated the hall nurse was supposed to make the changes for the discontinued Lasix on the MAR. The transcription error was caught when the end of month MARs were being reviewed.	F 281		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase	F 318		

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F 318	Continued From page 6 range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, record review and family and staff interviews the facility failed to provide Passive Range of Motion and hand splint application as recommended by Occupational Therapy for one (1) of one (1) sampled residents with contractures. (Resident # 60) The findings are: Resident # 60 was readmitted to the facility with diagnoses including persistent vegetative state, traumatic brain injury and seizure disorder. The quarterly Minimum Data Set (MDS) dated 01/18/12 revealed Resident # 60 had been assessed to require maximum assistance of two persons for activities of daily living. Assessment further indicated Resident # 60 had impaired range of motion on bilateral upper and lower extremities and was unable to communicate his needs due to his persistent vegetative state. The current care plan, which was last updated 03/15/12, included the goal and intervention of "resident will participate in passive range of motion (PROM) completing 2 sets of 10 repetitions (reps) thru next review". Care plan further indicated resident needs to wear palm guard with finger separators to left hand and left hand splint for 6-8 hours six times per week.	F 318	F 318 Resident # 60's restorative plan was reviewed by MDS nurse. Restorative plan was correct. Care guide was corrected to match care plan. Nurse to ensure compliance and that splints are applied. Audit was done of all residents requiring splints, ROM, & restorative services. A rehab. CNA is assigned to restorative and responsible for putting on splints. Case load was evaluated by MDS nurse according to care plan before assignment made. One full time and one part time CNA assigned to restorative nursing. Restorative nursing and application of splints will be provided to the residents by a restorative CNA according to the plan of care	

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F 318	Continued From page 7 Observations on 04/09/12 at 10:30 AM revealed Resident # 60 lying in bed with no splint or palm guard on his left hand. Observations on 04/10/2012 at 11:15 AM revealed Resident # 60 lying in bed, without splint or palm guard. Splints were observed to be lying on the dresser. An interview on 04/10/12 at 11:40 AM with family revealed splints lying on resident's dresser during both the day and evening shifts. The resident's family member indicated she had not seen range of motion completed on a routine basis in weeks. Review of restorative nursing documentation from 03/27/12 to 04/11/12 revealed that PROM and splint application had only been documented as being provided on 03/28/12, 04/07/12, and 04/10/12. During an interview with NA # 2 on 04/11/12 at 2:26 PM, the NA indicated she had completed PROM and applied the resident's splint on 04/11/12. She further indicated the restorative aide normally completed PROM and splint application, after the morning care or after showers. NA #5 indicated she helped the one full time restorative aide occasionally but knew restorative staff did not get a lot of other assistance. An interview with the Restorative Nursing aide on 04/11/12 at 2:35PM revealed she documented treatment provided in the computerized record system after care was provided. The Restorative aide further indicated Resident # 60 was to receive PROM daily, six days per week along with	F 318	Audits of 25% of residents receiving restorative will be conducted 2 X wkly. X 4 wks. Then monthly x 3 by the QI nurse and/or administrative nurse. Results will be reported to the monthly QI committee for follow-up and/or continued monitoring.	5-7-12

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F 318	Continued From page 8 placement of splints on his hands. When asked why PROM had not been completed with Resident # 60 the aide indicated she could not always get to every resident on her caseload. An interview with the facility Administrator on 04/12/12 at 2:35 PM revealed she would expect residents on the restorative caseload to receive range of motion and splint application per their care plan. She further indicated if restorative staff cannot provide services as specified on the plan of care, then nursing assistants could assist them.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to provide planned interventions to prevent injuries for one (1) of three (3) residents. Resident #14. The findings are: Resident #14 had diagnoses which included muscle weakness and abnormality of gait. The most recent annual MDS (Minimum Data Set) dated 05/29/11 assessed the resident with	F 323		

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F 323	Continued From page 9 memory problems, moderately impaired in cognition and as needing extensive assistance with ADL (Activities of Daily Living). The CAAS (Care Area Assessment Summary) triggered falls due to poor balance during transfers and a history of falls due to attempting to transfer by self without assistance. The Care Plan updated 02/13/12 focused on a risk for increase falls by history of falls related to impaired balance and poor cognition with goals to be free of falls through next review. Interventions included fall mat on floor when in bed. Record review revealed Resident #14 had a fall on 03/29/12 with no injuries. Review of the fall Incident Report dated 03/29/12 at 2:26 p.m. revealed the resident was found on the floor beside the bed. The resident was assessed for injuries and assisted back to bed. The resident's room was observed 04/09/12 at 1:00 p.m. No fall mat was noted anywhere in the room. Resident #14 was observed at random intervals on 04/09/12, 04/10/12, and 04/11/12. The resident propelled self independently and had on non skid socks, however no fall mat was noted anywhere in the resident's room. During an interview on 04/11/12 at 5 p.m. NA (Nurse Aide) #1 stated she was not sure if the resident was supposed to have a fall mat and had not seen a fall mat in the resident's room. NA #1 stated she thought the resident used to have a fall mat but did not know where it was. NA #1	F 323	F 323 Resident # 14's care guide was corrected 4-12-12. An audit of all care plans & care guides regarding falls was done for fall interventions. These were checked to make sure that all interventions were in place and were appropriate. In-service on care guides and corrected care guides was conducted on 5-3-12 with all nursing staff. Care plans were also compared to the care guides and incident reports. All preventive devices are in place. An audit of 20% of residents for preventive devices in place will be done 2 x / wk x 4 wks. Then monthly x 3 by the QI nurse and/or admin. nurse. Results will be reported to the QI committee for follow-up and/or continued monitoring.	5-7-12

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F 323	Continued From page 10 proceeded to go to the resident's closet and retrieve the Resident's Care Guide for falls which included: "mat on floor beside bed". During an interview on 04/12/12 at 10 a.m. LN (Licensed Nurse) #1 stated the resident was taking a nap on 03/29/12, had tried to get up by himself and appeared to have slid out of bed. LN #1 stated the resident was found sitting on the floor with his legs out in front and there was no mat on floor at the time. During an interview on 04/12/12 at 10:10 a.m. the DON (Director of Nursing) stated she expected the NAs to follow the Care Guide in each resident's closet. The DON further stated if specified in the Care Guide there should have been a fall mat if on the floor.	F 323		