

APR 15 2013

PRINTED: 01/08/2013
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345288	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/20/2012
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NAME OF PROVIDER OR SUPPLIER MAGNOLIA ESTATES SKILLED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey of 12/20/12. Event ID# 5XYD11.	F 000	F241 STANDARD DISCLAIMER: The Plan of Correction for this alleged deficient practice is provided as a necessary requirement of continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, medical record review and staff interviews the facility failed to obtain consent for posting of medical information of residents before posting the information in the residents' rooms. The information provided care information regarding code status and fall risk for two of five sampled residents for dignity. (Residents # 57 and 72.) The findings were: 1. Resident # 57 was admitted to the facility on 10/2/2010 with diagnoses including Dementia. Review of the Minimum Data Set dated 8/2012 revealed severe memory impairment. Observations on 12/18/12 at 1149 AM revealed Resident # 57 had a picture outline of a teddy bear posted above her bed. On the bear was a heart with a line through it in red and a yellow star on the left lower corner. Medical record review for Resident #57 did not	F 241	Resident #'s 57 currently has a signed consent acknowledging the facility may post medical information, in a coded format (e.g. 'care bear'), in the resident's room. Resident #72 discharged from the facility to an Assisted Living Facility on 01/02/2013. For those residents having the potential to be affected by the same alleged deficient practice, all residents and/or their responsible party received a Consent and Acknowledgement for Postings Related to Resident Care by mail. Individuals for whom the facility has not received the updated Consent and Acknowledgement, the postings have been removed. To ensure compliance, the Admissions Director shall ensure a resident and/or a responsible party's consent and or declination is obtained upon admission. Resident Room Postings shall only be used in rooms where either the resident or their responsible party has given appropriate consent for the posting. The consent shall be maintained in the Resident's Record such that facility staff are aware of the consent on file. The Social Worker and/or designee shall audit all in-house resident's files to ensure the appropriate consent for posting is on file and shall ensure the consent is on file prior to posting for newly admitted residents using the Consent and Acknowledgement for Postings Related to Resident Care Audit Tool. The Social Worker shall report all discrepancies related to the Consent for Posting with the Quality Assurance Committee monthly for three months, and quarterly thereafter to ensure compliance.	11/7/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	01/11/2013

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

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NAME OF PROVIDER OR SUPPLIER MAGNOLIA ESTATES SKILLED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159
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F 241	<p>Continued From page 1</p> <p>provide documentation of obtaining permission from the resident or responsible party for posting of information in the resident ' s room.</p> <p>Interview on 12/18/12 at 11:55 AM with aide #1 revealed the bears were posted to give them information about the resident. The heart with the line through it meant the resident was a Do Not Resuscitate. The yellow star informed staff the resident was a fall risk.</p> <p>Interview on 12/19/12 at 1:20 PM with the admissions coordinator revealed a letter was given to the residents and/or their responsible parties during the admission process. This letter indicated information would be displayed in their room. The letter was dated August 1, 2009 and signed by the administrator.</p> <p>The letter regarding posting of information in residents ' rooms was reviewed. The letter informed the resident/responsible party " As you ' ve noticed, the postings are coded using certain colors, markings and/or symbols so as to protect your or your loved one ' s privacy. These same colors, markings and/or symbols provide our staff with useful information. As always, if you have questions about the information provided through these postings, or should you elect the facility not to use such postings for you or your loved one; please do not hesitate to contact "</p> <p>Interview on 12/20/12 at 12:30 PM with the Administrator revealed a letter had been given to residents and/or their responsible party. Signage would be posted, and if a resident or responsible party did not want it used, they were to let the Social Worker or Administrator know. The letter</p>	F 241		
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NAME OF PROVIDER OR SUPPLIER MAGNOLIA ESTATES SKILLED CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159	
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F 241	<p>Continued From page 2</p> <p>was given during the admission process. When asked if permission had been obtained for Resident #57 from the responsible party before the signage was posted, he answered " no. "</p> <p>2. Resident #72 was admitted to the facility on 5/8/12 with diagnoses including Alzheimer ' s Dementia. Review of the Minimum Data Set (MDS) dated 10/30/12 revealed Resident #72 had memory impairment.</p> <p>Observations on 12/18/12 at 12:15 PM revealed Resident #72 had a picture outline of a teddy bear posted above his bed. On the bear was a heart with a line through it in red and a yellow star on the left lower corner.</p> <p>Medical record review for Resident #72 did not provide documentation of obtaining permission from the resident or responsible party for posting of information in the resident ' s room.</p> <p>Interview on 12/18/12 at 11:55 AM with aide #1 revealed the bears were posted to give them information about the resident. The heart with the line through it meant the resident was a Do Not Resuscitate. The yellow star informed staff the resident was a fall risk.</p> <p>Interview on 12/19/12 at 1:20 PM with the admissions coordinator revealed a letter was given to the residents and/or their responsible parties during the admission process. This letter indicated information would be displayed in their room. The letter was dated August 1, 2009 and signed by the administrator.</p>	F 241	

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F 241	<p>Continued From page 3</p> <p>The letter regarding posting of information in residents ' rooms was reviewed. The letter informed the resident/responsible party " As you ' ve noticed, the postings are coded using certain colors, markings and/or symbols so as to protect your or your loved one ' s privacy. These same colors, markings and/or symbols provide our staff with useful information. As always, if you have questions about the information provided through these postings, or should you elect the facility not to use such postings for you or your loved one; please do not hesitate to contact "</p> <p>Interview on 12/20/12 at 12:30 PM with the Administrator revealed a letter had been given to residents and/or their responsible party. Signage would be posted, and if a resident or responsible party did not want it used, they were to let the Social Worker or Administrator know. The letter was given during the admission process. When asked if permission had been obtained for Resident #72 from the responsible party before the signage was posted, he answered " no. "</p>	F 241		
F 431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted</p>	F 431		

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NAME OF PROVIDER OR SUPPLIER MAGNOLIA ESTATES SKILLED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159
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F 431	<p>Continued From page 4</p> <p>professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to maintain a secured narcotic storage lock box within the medication cart. The narcotic storage lock box was not permanently attached to the medication cart drawer for one of two medication carts. (300 hall medication cart)</p> <p>The findings were: On 12/20/12 at 2:20 PM the inspection of the stored medications was conducted. The 300 hall medication cart was unlocked by nurse #1. While checking the locked storage for controlled</p>	F 431	<p>F 431</p> <p>STANDARD DISCLAIMER: This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).</p> <p>No residents were specifically identified as having been affected by the alleged deficient practice.</p> <p>For those residents having the potential to be affected by the same alleged deficient practice, the narcotic storage lock box has been permanently affixed to the 300 hall medication cart. Additionally, the Director of Nursing and/or her designee shall verify the narcotic lock box of each medication cart is securely fastened to each medication cart by completing a physical inspection of the each cart weekly for 4 weeks, monthly for three months, and quarterly thereafter. Any narcotic lock box identified as not being permanently affixed/secured to a medication cart shall be repaired by the Maintenance staff.</p> <p>The Director of Nursing shall report any identified inconsistencies to the QA committee monthly for three months and quarterly thereafter.</p>	01/17/13
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NAME OF PROVIDER OR SUPPLIER MAGNOLIA ESTATES SKILLED CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159		
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F 431	Continued From page 5 narcotics, the lid was checked to ensure it was locked. The lid remained locked, but the entire contents of the narcotic box insert could be pulled out of the storage drawer. The locked insert did not have a sealed bottom and medications could be removed from the bottom. Nurse #1 was interviewed at the time the narcotic box insert was found not securely attached to the medication cart. Interview with nurse #1 revealed she was not aware the narcotics were not secured and could be removed from the medication cart. The Director of Nursing was informed on 12/20/12 at 2:25 PM of the findings on the 300 hall medication cart. Interview with the Director of Nursing revealed she was not aware there was a problem and called the maintenance department to check the cart and make repairs. Interview with nurse #2 on 12/20/12 at 2:30 PM revealed she was not aware of any routine checks made on the medication carts. Interview on 12/20/12 at 2:35 PM with the Director of Nursing revealed no definite routine maintenance checks were performed on the medication carts. The Administrator provided verbal information on 12/ 20/12 at 2:40 PM that the medication carts were routinely checked by their pharmacy. No further information was provided as to when they were last checked.	F 431			

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345288	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 12/20/2012
NAME OF PROVIDER OR SUPPLIER MAGNOLIA ESTATES SKILLED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 156	<p>Continued From Page 1 for his or her care.</p> <p>The facility must prominently display in the facility written information and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide required liability and appeal notices for one of three sampled residents (resident # 12).</p> <p>Findings include:</p> <p>Resident # 12 was admitted on 09/04/2012. The facility was able to provide documentation that resident #12 received an approved Notice of Medicare Non-coverage letter that notifies the resident Medicare services were ending, and her right to appeal; but could not provide documentation that resident #12 received a Denial Notice or SNF ABN (form CMS 10055); required for a resident staying in a Skilled Nursing facility transferring to Medicare B services (part A benefits remaining).</p> <p>In an interview on 12/20/12 at 4:30pm, the business office manager stated that she did not complete the required Appeals and beneficiary notice for the resident.</p> <p>In an interview on 12/20/12 at 4:30pm, the Administrator indicated it was his expectation for the residents to receive the required appeal and liability notices.</p>		

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NAME OF PROVIDER OR SUPPLIER MAGNOLIA ESTATES SKILLED CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159		
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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey of 12/20/12. Event ID# 5XYD11.	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345288	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/11/2013
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NAME OF PROVIDER OR SUPPLIER MAGNOLIA ESTATES SKILLED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159	FEB 12 2013
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K 000	INITIAL COMMENTS Surveyor: 02249 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type II (222) construction, two stories, with a complete automatic sprinkler system.	K 000		
K 051 SS=D	The deficiencies determined during the survey are as follows: NFFA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6	K 051		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE ADMINISTRATOR	(X6) DATE 1/23/2013
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER MAGNOLIA ESTATES SKILLED CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159	
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K 051	Continued From page 1	K 051	K051 No residents were specifically identified as having been affected by this alleged deficient practice.	
K 062 SS=D	This STANDARD is not met as evidenced by: Surveyor: 02249 Based on observation, on January 11, 2013 at approximately 10:00am onward, the audiovisual signaling device did not function for the fire alarm system - chime is located on the wall between rooms 303, and 305. 42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.6	K 062	K062 For those residents having the potential to be affected by the same alleged deficient practice, the audio/visual signaling device between rooms 303 and 305 has been repaired/replaced and is currently functioning properly. To ensure compliance and proper functioning, the Maintenance Director shall complete weekly tests of the audio/visual signaling device for 4 weeks, and monthly tests thereafter. The Maintenance Director shall record the tests on the audio/visual signaling device log for 4 weeks. Subsequent tests of the audio/visual signaling device's functioning shall be documented on the Maintenance Director's monthly fire alarm/drill report log(s). The Maintenance Director shall present to the Quality Assurance Committee the negative findings related to this plan of correction monthly for three months and quarterly thereafter.	02/25/13
K 071 SS=D	This STANDARD is not met as evidenced by: Surveyor: 02249 Based on observation, on January 11, 2013 at approximately 10:00am onward, there is paint on the sprinkler heat sensitive element - located in the shower and tub room beside room 100. 42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Rubbish Chutes, Incinerators and Laundry Chutes: (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor is sealed by fire resistive	K 071	K062 No residents were specifically identified as having been affected by this alleged deficient practice. For those residents having the potential to be affected by the same alleged deficient practice, the sprinkler heat sensitive element located in the shower and tub room beside room 100 has been repaired/replaced. To ensure compliance and proper functioning, the Maintenance Director shall complete a 100% inspection of all the sprinkler heads in the facility to ensure their heat sensitive elements are free from paint, etc. Any elements identified as being affected by paint shall be repaired/replaced. The Maintenance Director shall record the inspection(s) on the Sprinkler Inspection Log. Subsequent monthly inspections of the sprinklers' heat sensitive elements shall be conducted by the Maintenance Director and shall be documented on the Sprinkler Inspection Log. The Maintenance Director shall present to the Quality Assurance Committee the negative findings related to this plan of correction monthly for three months and quarterly thereafter.	02/25/13

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K 071	<p>Continued From page 2 construction to prevent further use or is provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes comply with section 9.5.</p> <p>(2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, is provided with automatic extinguishing protection in accordance with 9.7.</p> <p>(3) Any trash chute discharges into a trash collection room used for no other purpose and protected in accordance with 8.4.</p> <p>(4) Existing flue-fed incinerators are sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82</p> <p>This STANDARD is not met as evidenced by: Surveyor: 02249 Based on observation, on January 11, 2013 at approximately 10:00am onward, fire door latch is taped to prevent latching of laundry chute door. Latch is located in chute terminal room on the basement level.</p> <p>42 CFR 483.70(a)</p>	K 071	<p>K071 No residents were specifically identified as having been affected by this alleged deficient practice. For those residents having the potential to be affected by the same alleged deficient practice, the latch, located in the chute terminal room on the basement level, has been repaired. All Laundry personnel have been instructed on the importance of not taping the latch in the open position. To ensure compliance, the Environmental Services Director shall do daily inspections of the latch to ensure it is not taped or otherwise wedged in the open position. Such daily observations shall be documented on the Chute Terminal Latch log. Such observations shall be made daily for 2 weeks, and weekly on an on-going basis to ensure staff compliance. The Environmental Services' Director shall present to the Quality Assurance Committee the negative findings related to this plan of correction monthly for three months and quarterly thereafter.</p>	02/26/13	