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 08/28/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record review, family interview, staff interview and resident interview, the facility failed to provide 1 of 3 sampled residents with the number of showers preferred weekly. (Resident #99). The findings included: Resident #99 was admitted to the facility on 02/25/14. Her diagnoses included a traumatic brain injury, depressive disorder, and epilepsy. The admission Minimum data Set (MDS) dated 03/03/14 coded her as having clear speech, usually being understood and usually understands, but being cognitively impaired in that she could not answer any question on the brief interview for mental status. She was coded as having disorganized thinking, an altered level of consciousness and inattention. She had no behaviors during the assessment period. She was coded as requiring extensive assistance with bed mobility, transfers, toileting and hygiene and total assistance with bathing. She was coded as always being incontinent of bowel and bladder and as having no toileting program. She was	F 242	Magnolia Lane Nursing and Rehab 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 the Statement of Deficiencies through Informal Dispute Resolution formal appeal procedure and/or legal proceedings.	9/22/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/19/2014

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F 242	Continued From page 1 able to participate in the interview related to preferences at which time she stated her preference for choosing between a bath, shower and bed bath was very important to her. A care plan was developed on 03/12/14 which addressed her chronic progressive decline in intellectual functioning characterized by deficit in memory, judgment, decision making and thought process related to subdural hemorrhage. The care plan goal was for her to respond to questions/statements with appropriate verbalization. Interventions included to allow and or encourage the resident to make choices and to allow the resident sufficient time to verbalize needs. Review of bathing records since May of 2014 revealed she received a shower on 05/01/14, 05/05/14, 05/12/14, and on 05/15/14. On 05/22/14 she received a full bed bath. Showers were documented on 05/25/14 and 05/26/14. A full bed bath was documented on 05/29/14, on 06/04/14, on 06/05/14, and 06/07/14. She received a shower on 06/08/14, a full bed bath on 06/11/14, a shower on 06/14/14, 06/21/14 and 06/22/14. Resident #99 was hospitalized from 06/23/14 until 06/29/14. The first documented shower she received following her hospitalization was on 07/4/14, then again on 07/08/14, with a full bed bath documented on 07/11/14. Her next documented showers were on 07/20/14, on 07/22/14 then on 07/28/14. The next documented showers were on 08/01/14 then not again until 08/16/14, then on 08/20/14 and on 08/27/14.	F 242	Resident #99 was audited on 09-05-14 by the QI nurse for shower preferences. Resident did not state preferences. Resident□s POA contacted on 09-05-14 regarding preferences; POA stated at least twice per week. All residents were audited by the QI nurse for shower preferences by 09-05-14. Shower Books, with updated preferences, were put into place on 09-15-14. Residents may choose a shower or full bed bath or refuse. Residents requesting additional baths or showers, outside of stated preferences, will be worked into the schedule to accommodate their request. Staff Developer (SDC) in-serviced Nursing staff on 09-03-14 and 09-10-14 about shower choices; informing hall nurse of resident refusal; and documentation of all showers given or refused. Quality Improvement (QI) nurse or DON will audit 10% of resident population to ensure choices are reasonably accommodated utilizing a QI tool once every two weeks x 2 months; then monthly x 3 months; then quarterly x 3 quarters. Any concerns will be addressed as appropriate with findings reported in the morning department head meeting. The results of the audits will be reported to the monthly Quality Improvement Committee Meeting for identification of potential trends and development of plans of action and/or need for continued monitoring.	

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In between the documented showers and full baths were some partial baths. There were no documented types of baths, such as partials, documented on 27 days since 05/01/14.

Review of the resident care guide, kept in the closet for staff review, revealed it was last updated on 08/07/14 to include her preference for showers.

A family interview was conducted on 08/26/14 at 11:31 AM at which time the family expressed concern that Resident #99 was not receiving the number of showers she would like to have each week. The family stated that she would like at least 2 showers per week and he was under the impression, from the resident, she was only receiving 1 shower per week. He further stated that she expressed to him that she thought she smelled at times but he had not noticed any body odors.

On 08/28/14 at 8:12 AM, Resident #99 was interviewed related to her preference of baths and showers. She stated that she was not getting a shower as often as she would like, however, was then unable to tell the surveyor how often she would like to have a shower each week.

On 08/28/14 at 8:57 AM Nurse Aide (NA) #2, who completed showers was interviewed. She stated that Resident #99 was scheduled for showers on Tuesdays and Fridays. NA #2 stated she usually did not refuse a shower and had occasionally asked for an additional shower. She stated she used to document showers she gave on paper but now the facility management wanted her to document in the computer system. She stated if

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F 242	Continued From page 3 she was unable to complete all of her showers, or residents refused a shower then she tried to make it up the next day. She further stated Wednesdays and Saturdays were make up days for showers missed. If she was unable to give someone a shower, then she also told second shift about the missed shower. Interview with the Director of Nursing on 08/28/14 at 4:09 PM revealed a partial bed bath included washing a resident's face, under the arms, under the breasts, and the periarea. She further stated that showers should be given at least twice per week and as the resident preferred.	F 242		
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, record review, and staff interviews, the facility failed to provide an individual activity program for 1 of 3 sampled residents when Resident #99's condition changed. The findings included: Resident #99 was admitted to the facility on 02/25/14. Her diagnoses included a traumatic brain injury, depressive disorder, and epilepsy.	F 248	All residents, inclusive of #99, had a new Activity Assessment completed by the Activity Manager by 09-10-14. The QI nurse updated the care plans by 09-30-14. All residents were audited by the Director of Nursing (DON) by 09-29-14 to ensure a minimum of two activities per week were provided to meet the resident□s' needs as noted by their preferences; and the activities program was meeting residents' needs as noted by their preferences. The Activity Manager	9/30/14

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F 248	Continued From page 4 The admission Minimum data Set (MDS) dated 03/03/14 coded her as having clear speech, was usually understood and usually understands, but being cognitively impaired in that she could not answer any question on the brief interview for mental status. She was coded as having disorganized thinking, an altered level of consciousness and inattention. She had no behaviors during the assessment period. She was coded as requiring extensive assistance with bed mobility, transfers, and toileting. She was coded as ambulating only once or twice during the assessment period with no staff support. This MDS indicated that per the resident, the activities of listening to music, being around animals, keeping up with the news, doing things with groups of people, getting outside and participating in religious activities were very important to her. The initial activity assessment dated 03/04/14 indicated her activity preferences were both in large and small groups, in and out of her room, doing individual activities and going on outings. Her interests included arts and crafts, flowers, gardening, sewing, sports, bingo, board games, card games and word games, singing hymns and attending worship services, listening to music, watching TV and watching movies. There was no care plan specific for activities originally. Review of the participation records revealed Resident #99 actively participated in group activities including social programs, exercise, bingo, music programs, special events as well as sensory stimulation programs on an individual level. The participation records revealed	F 248	was in-serviced on 09-03-14 by SDC to provide an individualized activity program for all residents; to provide more activities; and to capture, via clear documentation, all attempts at activities. Nursing staff was in-serviced 09-03-14 by SDC about providing activities to residents and clearly documenting activity interactions. QI nurse or DON will randomly audit 10% of resident population to ensure that a minimum of 2 activities per week were provided and the activities program was meeting the residents' needs as noted by their preferences utilizing a QI tool weekly x 4 weeks; then monthly x 2 months; then quarterly x 3 quarters. Any concerns will be addressed as appropriate with findings reported in the morning department head meeting. The results of the audits will be reported to the monthly Quality Improvement Committee Meeting for identification of potential trends and development of plans of action and/or need for continued monitoring.	

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Resident #99 attended 3 activity programs in February 2014; 17 in March 2014; 24 in April 2014 and 17 between May 1st and May 17th, 2014.

Nursing notes revealed Resident #99 fell and fractured her right humerus on 05/17/14. The physician opted to treat the fracture nonsurgically per his note on 05/27/14.

Activity participation records revealed Resident #99 did not attend any group activity program after the 05/17/14 fall. The records revealed she did independent activities including watching television and family visits 10 of the remaining days in May 2014. In June 2014 she did individual activities 22 days primarily watching television. On 06/10/14 she attended a music program and on 06/17/14 she attended a sensory stimulation program.

On 06/13/14 a care plan was developed for feelings of sadness, anxiety, tearfulness, depression, and withdrawal from care and or activities related to a fracture and requiring more assistance than usual. The goal was to have an improved mood stated as evidenced by a happier, calmer appearance. Interventions included encouraging resident to attend group activities, and offer activities of which resident has shown an interest.

The activity participation record continued to note that in July 2014 Resident #99 was visited for socialization 3 times for 10 minutes each and attended 1 exercise program. Individual independent activities included television and family visits 25 days. She went to the beauty shop once. In August 2014 she attended a social

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program and was visited by activity staff 3 times for 10 minutes each time. She was noted as watching television daily.

Resident #99 was observed awake in bed, the television on the following times: 08/25/14 at 10:01 AM; 08/26/14 at 11:25 AM; 08/27/14 at 8:26 AM; 08/28/14 at 8:12 AM; 08/28/14 at 8:33 AM; and 08/28/14 at 3:14 PM.

Interview with the Activity Director (AD) on 08/28/14 at 3:00 PM revealed that Resident #99 was very active with different programs including bingo until she fractured her arm. The AD stated that since she fractured her arm she never sees her out of bed. She further stated that yesterday was the first time she had been out of bed in a long while. When asked about the participation records, the AD stated she probably does not capture all her attempts to see the resident. She stated her goal was to see Resident #99 once per week to talk and paint her nails but she was often sleeping. AD stated she needed to make more of an attempt to involve the resident in activities.

An attempt to interview Resident #99 about her interests in activities was made on 08/28/14 at 3:14 PM. She was awake and the television was on. She started to speak but could not answer any question including yes or no questions due to her neurological condition and inability to always verbalize her words.

Interview with the Director of Nursing on 08/28/14 at 5:09 PM revealed she expected all staff to spend time with the resident and work together to get her out of bed in order to participate in activities.

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F 280	Continued From page 7	F 280		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff interviews and resident interviews, the facility failed to review and revise care plan interventions for falls for 2 of 5 sampled residents. (Residents #99 and #106). The findings included: 1. Resident #99 was admitted to the facility on 2/25/14. Her diagnoses included a traumatic brain injury, depressive disorder, and epilepsy.	F 280	Resident #99 and #106 had their care plans and care guides updated by 09-11-14 by the QI nurse with all corresponding interventions in place. All residents□ care plans and care guides were audited and updated by QI nurse by 09-11-14. All interventions noted on care plan were placed on corresponding care guides. The QI nurse audited all resident rooms to ensure interventions were in place, as noted on care plan/care guide.	9/22/14

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F 280	Continued From page 8 Nursing notes dated 03/02/14 at 10:47 AM revealed a visitor alerted staff that Resident #99 was on the floor by the nursing station. She sustained a hematoma above her left eyebrow and was sent to the emergency room for evaluation. The incident report noted in response to the fall, a nonskid dycem pad was placed in her chair. The admission Minimum data Set (MDS) dated 3/3/14 coded her as having clear speech, usually understood and usually understands, but being cognitively impaired in that she could not answer any question on the brief interview for mental status. She was coded as having disorganized thinking, an altered level of consciousness and inattention. She had no behaviors during the assessment period. She was coded as requiring extensive assistance with bed mobility, transfers, and toileting. She was able to feed self with supervision and had no range of motion impairments. She was coded as ambulating only once or twice during the assessment period with no staff support. She was coded as always being incontinent of bowel and bladder and as having no toileting program. This MDS noted no falls prior to admission but having had 2 falls with no injury since admission. Nursing notes dated 03/04/14 at 8:00 PM stated Resident #99 was found sitting on the bathroom floor. The resident stated at the time that she went to use the bathroom alone and slipped. She was subsequently placed back into her wheelchair and then to bed and encouraged to use her call bell. In response, the incident report stated slip strips were to be added to the floor by the bed, skin and toilet.	F 280	If intervention was missing, it was put in place immediately. QI nurse was in-serviced by SDC on 09-03-14 to ensure care plan and care guides matched at all times□when updates are added/deleted, care plans and care guides are immediately altered to reflect changes and new care guides are immediately posted in resident□s closet. Nursing staff was in-serviced by SDC on 09-03-14 for following the care guide interventions. DON or SDC will audit 10% of resident population for care plan and care guide match and to ensure interventions are in place and effective utilizing a QI tool weekly x 4 weeks; then monthly x 2 months; then quarterly x 3 quarters. Any concerns will be addressed as appropriate with findings reported in the morning department head meeting. The results of the audits will be reported to the monthly Quality Improvement Committee Meeting for identification of potential trends and development of plans of action and/or need for continued monitoring.	

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A Quality Improvement (QI) note for falls was dated 03/05/14 which included review of 3 falls: one on 03/02/14 with dycem added; one on 03/03/14 when the resident fell from bed and a fall mat was added; and one for 03/04/14 when a chair alarm was added.

A care plan for a risk for falls and actual falls due to impaired cognition and impaired mobility was initiated on 03/12/14. The goal was for Resident #99 to not sustain serious injury through the next review. Interventions included:
*assist during transfer and mobility;
*encourage resident to wear glasses;
*rehab therapy referral;
*fall mat on floor when in bed;
*nonskid trips on floor;
*wheelchair with dycem when out of bed.
The chair alarm was not added to the interventions at this time.

A nursing note dated 03/28/14 as a late entry for 03/27/14 at 9:35 PM noted the resident was sitting on the floor and the chair alarm was not turned on. Resident stated that she had to use the bathroom. The QI noted dated 04/01/14 noted the action taken was to remind the resident to use the call light for assistance for toileting and other needs. The alarm was replaced and her medications were reviewed due to behaviors. Again no chair alarm was added as an intervention to the care plan.

A nursing note dated 04/26/14 at 12:33 PM revealed Resident #99 was lying on the floor at the entrance to the bathroom. The wheelchair alarm's volume was turned down. The resident stated she fell trying to use the bathroom. The incident report revealed the resident and

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roommate both stated Resident #99 had asked the roommate to put the call light on for her. The incident report and the QI note dated 04/28/14 noted that staff were educated to check alarms for sound and function and the resident was asked to wait for staff assistance before transferring alone.

A nursing note on 05/17/14 at 4:29 AM stated the resident was found sitting on the floor in front of the open door to her room with her legs bent and feet on the floor. She was holding her right arm with her left hand complaining of severe pain. She was unable to lift her right arm. The resident stated she was self ambulating from the bathroom back to bed. The nursing note stated a bed alarm was placed on the bed. Resident #99 was sent to the hospital for an X-ray of her arm. The hospital records dated 05/17/14 noted a closed fracture of the clavicle. She was subsequently treated with a sling. A follow up consult report dated 05/27/14 noted a 2 part humerus fracture with some displacement to be treated nonsurgically.

The care plan was updated on 05/17/14 to include a bed alarm, however, the chair alarm was not added to the care plan.

A significant change MDS dated 5/30/14 coded her with moderately impaired cognition, feeling down, tired and bad about self,moving or speaking slowly, having no behaviors, being nonambulatory, requiring extensive assistance with eating, having impairment on one side and being occasionally incontinent of bladder and always being continent of bowel. She was coded as being on no toileting plan and having one fall since the previous assessment with a major

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injury.

Review of the resident care guide kept in the closet revealed the mat on the floor was initiated on 03/05/14, the nonslip strips at sink and toilet and dycem were added on 03/05/14, and the bed alarm was initiated on 07/18/14. This care guide was last updated 08/07/14 and still did not have the chair alarm added.

Resident #99 was observed awake in bed without an alarm or mat on the floor at the following times: 08/25/14 at 10:01 AM, 08/26/14 at 11:25 AM; 08/27/14 at 8:26 AM; 08/28/14 at 8:12 AM; 08/28/14 at 8:33 AM and 08/28/14 at 3:14 AM. There were also no nonskid strips on the floor.

On 08/28/14 at 8:46 AM, Nurse Aide (NA) #1 stated she has been in the facility about a month and has not seen floor mats or an alarm in use for Resident #99. She further stated on 08/28/14 at 8:50 AM stated she knew what individual care a resident needed by the posted care guide in the resident's closet.

Interview with the QI nurse on 08/27/14 at 3:38 PM revealed the QI nurse would let the MDS nurse know what interventions were planned after a fall and the MDS nurse would then revise and update the resident's care plan and resident's care guides and they should match. The current QI nurse stated that the alarm in the bed for Resident #106 was discontinued on 08/14/13 because the resident kept removing it. In addition, she thought that the nonskid strips on the floor may have been placed at one time and the resident since moved to a different room and the strips did not move with her.

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The certified occupational therapy aide (COTA) who has worked with Resident #99 for months stated on 08/28/14 at 12:30 PM she could not recall an alarm being on her bed or if there was a mat on the floor or nonskid strips by the bed. She further stated that Resident #9 had moved rooms a couple of times since admission.

Nurse #1 stated on 08/28/14 at 1:08 PM that she could not recall strips on the floor or a nonskid mat and she was not sure if an alarm had been on and when she last saw it. She further stated that often interventions were placed on residents, such as an alarm, and nurses were not informed about the addition of the intervention.

Interview with the Director of Nursing on 08/28/14 at 4:09 PM revealed the care guides and care plans should match and interventions checked to see they were in place. She further stated interventions were reviewed at daily stand up meeting following each fall.

2. Resident #106 was admitted to the facility on 05/16/14 with diagnoses including urinary tract infection, acute kidney injury, encephalopathy due to sepsis, diabetes, and chronic obstructive pulmonary disease.

Resident #106 had the following falls and interventions per incident report review:
*05/17/14 at 2:29 AM when she was hiding under her bed looking for the voices she was hearing. A bed alarm was initiated as an intervention to prevent further falls.
*05/17/14 2:41 PM when she was found approximately 6 feet from her wheelchair on the floor. A chair alarm was added as an intervention to prevent further falls.

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*05/17/14 at 2:56 PM when she was found on floor in day room. A pillow and incontinent pad were removed from the seat of her wheelchair.
*05/20/14 at 1:47 AM when she was found on the floor and she stated she slipped when exiting her chair. She had removed her nonskid socks so family was asked to encourage Resident #106 to wear them.

The admission Minimum Data Set (MDS) dated 05/22/14 coded her with severely impaired cognitive skills, requiring limited assistance with bed mobility, transfers, dressing and toileting. She walked with supervision and took antipsychotic medications. She had no history of falls prior to admission but had experienced falls since admission to the facility.

A care plan was developed on 05/27/14 with a goal for Resident #106 to be free from falls. Care plan interventions included assisting her during transfers and mobility, encouraging her to participate in activities that promote exercise, provide a rehab referral, keep call light in reach, place a dycem in her wheelchair and having a bed and chair alarm.

The Care Area assessment dated 06/03/14 noted she had an unsteady gait.

Per the incident report, Resident #106 fell on 06/14/14 at 4:36 PM when she was found on the floor on her back. She stated she was trying to get in bed and fell. Nursing notes dated 06/16/14 at 4:27 PM that the resident reported she fell transferring herself from bed to her wheelchair around 10:30 AM and got herself back into the wheelchair. The investigation did not indicate if the chair or bed alarms were in use and working.

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The action taken was an anti-rollback device added on her wheelchair. The care plan was updated on 06/24/14 with this intervention.

An incident report indicated Resident #106 fell on 06/28/14 at 6:24 AM when she rolled out of bed onto her face.

Resident #106 fell on 07/08/14 at 3:46 AM when, per the incident report, she was found sitting in front of the bathroom door. The bed alarm was disconnected and the resident denied disconnecting it. The investigation did not include follow up as to how the alarm was disconnected.

Resident #106 fell again on 07/11/14 at 2:00 AM per incident report when she was found sitting on the floor in front of her bed. She stated she was going to go to the bathroom. The Quality Improvement (QI) note dated 07/17/14 noted that nonslip socks were encouraged. Another QI note dated 07/21/14 stated an additional intervention was to place nonslip strips to the floor at the resident's bedside. This intervention was not added to the plan of care.

The incident report noted Resident #106's last fall was on 07/31/14 at 11:13 PM when she fell trying to get into bed. Staff were alerted when the roommate was heard hollering down the hall. The report did not identify if the alarm was sounding. The interventions were noted that she already had a chair alarm and staff were instructed to check prior to shift change to anticipate needs.

Resident #106 was observed on 08/26/14 at 4:20 PM laying across her bed without an alarm in bed and no nonslip strips were on the floor or in her bathroom. No alarm was observed in place

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when she was observed in bed on 08/27/14 at 8:34 AM and no nonslip strips were on the floor. She was in the wheelchair with an alarm on the wheelchair on 08/27/14 at 9:20 AM, 08/27/14 at 10:00 AM. She was observed on 08/27/14 at 3:13 with the Director of Nursing sitting on the bed without an alarm on the bed and no nonslip strips on the floor by the bed or bathroom. Review of the resident's care guide in the closet dated 08/14/14 revealed she was supposed to have a bed alarm, nonskid strips by bed and bathroom, and a dycem in the wheelchair. There was nothing related to a chair alarm. The DON confirmed no bed alarm was in place and nonskid strips were not on the floor by her bed. The DON stated the resident's care guide, used by nurse aides, and the resident's care plan should match. The DON stated the interventions were to be checked to assure they were in place and matched planned interventions by restorative nurse aides and weekend managers.

Interview with the QI nurse on 08/27/14 at 3:38 PM revealed the QI nurse would let the MDS nurse know what interventions were planned after a fall and the MDS nurse would then revise and update the resident's care plan and resident's care guides and they should match. The current QI nurse stated that the alarm in the bed for Resident #106 was discontinued on 08/14/13 because the resident kept removing it. In addition, she thought that the nonskid strips on the floor may have been placed at one time and the resident since moved to a different room and the strips did not move with her.

Review of the resident's falls and interventions with the DON and Administrator on 08/28/14 at 4:09 PM revealed that review of the medical

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F 280	Continued From page 16 record the care plans did not include the floor strips as a fall intervention.	F 280		
F 323 SS=G	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, record review and staff interviews, the facility failed to identify trends of fall circumstances and implement care planned interventions for 2 of 5 sampled residents reviewed for falls. Resident #99 fractured her arm when she fell the fourth time while ambulating by herself to the bathroom. Residents #99 and #106 did not have the care planned interventions in place to prevent falls. The findings included: 1. Resident #99 was admitted to the facility on 02/25/14. Her diagnoses included a traumatic brain injury, depressive disorder, and epilepsy. Nursing notes dated 03/02/14 at 10:47 AM revealed a visitor alerted staff that Resident #99 was on the floor by the nursing station. She sustained a hematoma above her left eyebrow and was sent to the emergency room for evaluation. The incident report noted in response	F 323	Resident #99 and #106 had their care plans and care guides audited by the QI nurse and was updated to include planned interventions for falls on 09-11-14. The QI nurse audited #99 and #106 rooms by 09-11-14 to ensure that fall preventions were in place as noted on care plans and care guides and if missing, put in place immediately. All residents□ care plans and care guides were audited by the QI nurse by 09-11-14 for fall interventions. The QI nurse audited all resident rooms by 09-11-14 to ensure interventions were in place, as noted on care plan/care guide. If intervention was missing, it was put in place immediately. Nursing staff was in-serviced by SDC on fall interventions; calling the DON and/or Administrator upon occurrence and completed by 09-03-14. All nursing staff was also in-serviced by the SDC for	9/22/14

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F 323	Continued From page 17 to the fall, a nonskid dycem pad was placed in her chair. The admission Minimum Data Set (MDS) dated 03/03/14, indicated the resident had clear speech, was usually understood and could usually understand others, but cognitively impaired in that she could not answer any question on the brief interview for mental status. She was coded as having disorganized thinking, an altered level of consciousness and inattention. She had no behaviors during the assessment period. She was coded as requiring extensive assistance with bed mobility, transfers, and toileting. She was coded as ambulating only once or twice during the assessment period with no staff support. She was coded as always being incontinent of bowel and bladder and as having no toileting program. This MDS noted no falls prior to admission but having had 2 falls with no injury since admission. Nursing notes dated 03/04/14 at 8:00 PM stated Resident #99 was found sitting on the bathroom floor. The resident stated at the time that she went to use the bathroom alone and slipped. She was subsequently placed back into her wheelchair and then to bed and encouraged to use her call bell. In response, the incident report stated non slip strips were to be added to the floor by the bed, sink and toilet. A Quality Improvement (QI) note for falls was dated 03/05/14 which included review of 3 falls: one on 03/02/14 with dycem added; one on 03/03/14 when the resident fell from bed and a fall mat was added; and one for 03/04/14 when a chair alarm was added.	F 323	following care guides and fall interventions and completed by 09-05-14. Twenty-four hour reports are reviewed by the Director of Nursing (DON) daily for any falls (M-F). Any falls noted are reviewed by interdisciplinary team for appropriate fall interventions□care plans and care guides are updated at this time. Falls are to be reported to the DON and/or Administrator, upon occurrence, to determine if additional fall interventions need to be implemented. All falls are reviewed weekly at Fall Meeting where interventions are discussed; care plans and care guides are reviewed and trends or patterns identified. DON or SDC nurse will conduct an audit utilizing QI tool of all falls to determine if care plan and care guide match and that interventions are in place and are effective weekly x 4 weeks; then monthly x 2 months; then quarterly x 3 quarters. Any concerns will be addressed as appropriate with findings reported in the morning department head meeting. The results of the audits will be reported to the monthly Quality Improvement Committee Meeting for identification of potential trends and development of plans of action and/or need for continued monitoring.	

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A care plan for a risk for falls and actual falls due to impaired cognition and impaired mobility was initiated on 03/12/14. The goal was for Resident #99 to not sustain serious injury through the next review. Interventions included:
*fall mat on floor when in bed;
*nonskid strips on floor;
*wheelchair with dycem when out of bed.
This care plan did not include the intervention of the chair alarm.

In addition another care plan developed on 03/12/14 included an intervention to transfer providing one-person constant guidance and physical assistance.

A nursing note dated 03/28/14 as a late entry for 03/27/14 at 9:35 PM noted the resident was found sitting on the floor and the chair alarm was not turned on. Resident #99 stated that she had to use the bathroom. The QI note dated 04/01/14 noted the action taken was to remind the resident to use the call light for assistance for toileting and other needs. The chair alarm was replaced and her medications were reviewed due to behaviors. There was no investigation to determine how or why the alarm was not on.

A nursing note dated 04/26/14 at 12:33 PM revealed Resident #99 was lying on the floor at the entrance to the bathroom. The wheelchair alarm's volume was turned down. The resident stated she fell trying to use the bathroom. The incident report revealed the resident and roommate both stated Resident #99 had asked the roommate to put the call light on for her. The incident report and the QI note dated 04/28/14 noted that staff were educated to check alarms for sound and function and the resident was

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asked to wait for staff assistance before transferring alone. The investigation did not include who was responsible for turning the alarm down. Resident #99 was noted on the investigation as being oriented to place and person only.

A nursing note on 05/17/14 at 4:29 AM stated the resident was found sitting on the floor in front of the open door to her room with her legs bent and feet on the floor. She was holding her right arm with her left hand complaining of severe pain. She was unable to lift her right arm. The resident stated she was self ambulating from the bathroom back to bed. The nursing note stated a bed alarm was placed on the bed. Resident #99 was sent to the hospital for an X-ray of her arm. The hospital records dated 05/17/14 noted a closed fracture of the clavicle. She was subsequently treated with a sling. A follow up consult report dated 05/27/14 noted a 2 part humerus fracture with some displacement to be treated nonsurgically. The investigation did not include information as to whether the alarm was sounding at the time of the fall. Attempts to call the nurse who wrote the nursing note related to this fall were unsuccessful. She no longer worked in the facility.

Review of the care plan for falls, which was maintained in the computer system, revealed the addition of a bed alarm was placed on the care plan on 05/17/14.
This was the current care plan at the time of the survey for Resident #99.

A significant change MDS dated 5/30/14 coded her with moderately impaired cognition, feeling down, tired and bad about self, moving or

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speaking slowly, having no behaviors, being nonambulatory, requiring extensive assistance with eating, having impairment on one side and being occasionally incontinent of bladder and always being continent of bowel. She was coded as being on no toileting plan and having one fall since the previous assessment with a major injury.

In addition to the care plan, individual care guides were taped inside the closet door of each resident. The care guide for Resident #99 located in the closet door and dated 08/07/14 had the interventions including mat on floor bedside bed: non skid, sensory alarm to bed, dycem to wheelchair, and slip strips at sink and toilet in room.

Resident #99 was observed awake in bed without an alarm or mat on the floor at the following times: 08/25/14 at 10:01 AM, 08/26/14 at 11:25 AM; 08/27/14 at 8:26 AM; 08/28/14 at 8:12 AM; 08/28/14 at 8:33 AM and 08/28/14 at 3:14 AM. There were also no nonskid strips observed on the floor at these same times.

The Administrator and Director of Nursing were interviewed on 08/27/14 at 2:02 PM regarding Resident #99's falls and interventions. Neither were working at the facility at the time of these events. Both reviewed the nursing notes and incident reports. Both confirmed that Resident #99 fell 3 times taking herself to the bathroom (03/04/14, 03/27/14 and 04/26/14). They confirmed there was no evidence that Resident #99's repeated attempts to toilet herself at the time of each fall had been identified or addressed before she fell and fractured her arm on 05/17/14 when she again transported herself to the

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bathroom.

On 08/28/14 at 8:46 AM, Nurse Aide (NA) #1 stated she has been in the facility about a month and has not seen floor mats or an alarm in use for Resident #99. She further stated on 08/28/14 at 8:50 AM stated she knew what individual care a resident needed by the posted care guide in the resident's closet.

Interview with the current QI nurse on 08/28/14 at 11:32 AM revealed that up until a month ago she was the MDS nurse and then became the QI nurse. The previous QI nurse was no longer working in the facility. The current QI nurse stated that the previous QI nurse was responsible for tracking and trending falls and putting interventions in place specific to the trends. The former QI nurse then emailed the MDS nurse to update the care plans and care guides in the resident's closet. She stated the previous QI nurse should have identified the trend of Resident #99 falling when taking herself to the bathroom. She further stated that when working as the MDS nurse she never considered a toileting program during the time Resident #99 was falling as she was occasionally incontinent and dribbled. The QI nurse further stated that Resident #99 would take herself to the bathroom and she would have to be reminded not to take herself. Since the fracture, the QI nurse stated Resident #99 had undergone a significant change.

The certified occupational therapy aide (COTA) who has worked with Resident #99 for months stated on 08/28/14 at 12:30 PM she could not recall an alarm being on her bed or if there was a mat on the floor or nonskid strips by the bed. She further stated that Resident #9 had moved rooms

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a couple of times since admission.

Nurse #1 stated on 08/28/14 at 1:08 PM that she could not recall strips on the floor or a nonskid mat and she was not sure if an alarm had been on and/or when she last saw it. She further stated that often interventions were placed on residents, such as an alarm, and nurses were not informed about the addition of the intervention.

Interview with the Director of Nursing on 08/28/14 at 2:28 PM revealed the care guides and care plans should match and interventions checked to see they were in place.

Follow up interview with the DON on 08/28/14 at 4:09 PM revealed they have identified falls as a problem and currently review all accidents and circumstances surrounding a resident's fall. Each investigation is reviewed to ensure the intervention in place is appropriate. The DON also stated they were auditing each resident daily to ensure the alarm was on the resident as care planned.

2. Resident #106 was admitted to the facility on 05/16/14 with diagnoses including urinary tract infection, acute kidney injury, encephalopathy due to sepsis, diabetes, and chronic obstructive pulmonary disease.

Resident #106 had the following falls and interventions per incident report review:
*05/17/14 at 2:29 AM when she was hiding under her bed looking for the voices she was hearing. A bed alarm was initiated as an intervention to prevent further falls.
*05/17/14 2:41 PM when she was found approximately 6 feet from her wheelchair on the

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floor. A chair alarm was added as an intervention to prevent further falls.
*05/17/14 at 2:56 PM when she was found on floor in day room. A pillow and incontinent pad were removed from the seat of her wheelchair.
*05/20/14 at 1:47 AM when she was found on the floor and she stated she slipped when exiting her chair. She had removed her nonskid socks so family was asked to encourage Resident #106 to wear them.

The admission Minimum Data Set (MDS) dated 05/22/14 coded her with severely impaired cognitive skills, requiring limited assistance with bed mobility, transfers, dressing and toileting. She walked with supervision and took antipsychotic medications. She had no history of falls prior to admission but had experienced falls since admission to this facility.

A care plan was developed on 05/27/14 with a goal for Resident #106 to be free from falls. Care plan interventions included assisting her during transfers and mobility and to have a bed alarm and chair alarm in place.

The Care Area Assessment dated 06/03/14 noted Resident #106 had an unsteady gait.

Per the incident report, Resident #106 fell on 06/14/14 at 4:36 PM when she was found on the floor on her back. She stated she was trying to get in bed and fell. The investigation did not identify if the chair alarm sounded or was in use at the time the resident was found. Under the section on the incident report for predisposing situational factors, a check was placed by "non-compliance", however, no further description was included in the remarks section. The action

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	345219	A. BUILDING _____ B. WING _____	C 08/28/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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taken was an anti-rollback device added on her wheelchair. A Quality Improvement note dated 06/16/14 at 4:27 PM, related to this same incident, stated the nurse reported Resident #106 fell while transferring from the bed to her wheelchair. The note did not address the presence of either a chair or bed alarm. The care plan was updated on 06/24/14 with the intervention of anti-roll backs to her wheelchair.

An incident report indicated Resident #106 fell on 06/28/14 at 6:24 AM when she rolled out of bed onto her face. This was a witnessed event. The nursing note stated that she was placed back in bed and the bed alarm was checked and in working order.

Resident #106 fell on 07/08/14 at 3:46 AM when, per the incident report, she was found sitting in front of the bathroom door. The bed alarm was disconnected and the resident denied disconnecting it. There was no further documented investigation regarding how the alarm was disconnected. Interview with the Director of Nursing (DON) and Administrator on 08/27/14 at 2:02 PM while reviewing residents' falls, revealed this fall occurred on the DON's her first day of employment and it would have been discussed in morning meeting the next day. Neither the Administrator or DON could state what was investigated relating to the disconnected alarm. The Administrator further stated they were going to audit chair and bed alarms and refer to therapy after each fall.

Resident #106 fell again on 07/11/14 at 2:00 AM per incident report when she was found sitting on the floor in front of her bed. She stated she was going to go to the bathroom. The Quality

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Improvement (QI) note dated 07/17/14 noted that nonslip socks were encouraged. Another QI note dated 07/21/14 stated an additional intervention was to place nonslip strips to the floor at the resident's bedside. This intervention was not added to the plan of care.

The incident reports revealed Resident #106's last fall was on 07/31/14 at 11:13 PM when she fell trying to get into bed. The report did not specify if the resident transferred from her wheelchair or where she was previous to the fall. The incident report stated the roommate was hollering down the hall and the resident was observed sitting on the floor. The report did not address if the chair alarm was sounding. The interventions were noted on 08/01/14 that she already had a chair alarm and staff were instructed to check prior to shift change to anticipate needs.

Resident #106 was observed on 08/26/14 at 4:20 PM laying across her bed without a bed alarm in place and without nonskid strips located by the bed or bathroom. No alarm was in bed when the resident was observed in bed on 08/27/14 at 8:34 AM and no nonskid strips were noted on the floor by her bed. She was observed on 08/27/14 at 3:13 PM with the DON sitting on the bed without a bed alarm in place and there were no nonskid strips on the floor by her bed or bathroom. Review of the resident care guide in the closet dated 08/14/14 revealed she was supposed to have a bed alarm and nonskid strips by bed and bathroom. The DON confirmed no bed alarm was in place and nonskid strips were not on the floor by her bed. The DON stated the interventions in the resident's care guide, used by nurse aides, and the interventions in the

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resident's care plan should match. The DON stated the interventions were to be checked as being in place by restorative nurse aides and weekend managers.

Interview with the current QI nurse on 08/27/14 at 3:38 PM revealed the QI nurse would let the MDS nurse know what interventions were planned after the fall and the MDS nurse would then revise and update the resident's care plan and resident's care guide and they should match. The QI nurse stated the nonskid floor strips may have been placed at one time for Resident #6, but the resident had moved to a different room and staff failed to place these strips in the resident's new room.

On 08/28/14 at 8:46 AM, Nurse Aide (NA) #1 stated she had worked in the facility about a month and she knew what individual care a resident needed by the posted care guide in the resident's closet.

Review of the resident's falls and interventions with the DON and Administrator on 08/28/14 at 4:09 PM revealed that review of the medical record the care plans did not include the floor strips as a fall intervention.