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 _____	R-C 10/22/2015

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

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{F 514} SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to document severity of pain or response to pain medications for 2 of 5 residents (Resident #71 and Resident #4) that were sampled for documenting pain severity and documenting the effectiveness of pain medications. The findings include: 1. Resident #71 was readmitted to facility from acute care hospital on 01/15/15 with diagnosis of dementia, anxiety, and chronic obstructive pulmonary disease. Resident #71's most recent comprehensive MDS (Minimum Data Set) dated 05/18/15 indicated that Resident #71 was cognitively intact for daily decision making and indicated that Resident #71 reported pain occasionally.	{F 514}	F 514 Resident Records-Complete/Accurate/Accessible On 10/22/15, the treatment nurse assessed resident # 4 for pain. The treatment nurse documented assessment of pain in the progress notes. On 10/23/15, resident #71 was given prn medication and assessed for pain with follow up by the hall nurse. The hall nurse documented the pain assessment with effectiveness on the back of the MAR. On 10/29/15, a Pain Assessment was completed in the electronic medical record. On 11/6/15, the nurse practitioner evaluated resident #71 and wrote new orders to change resident #71's pain medication to a scheduled dosing regimen.	11/11/15

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

Electronically Signed

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{F 514}	Continued From page 1 Review of physician orders for Resident #71 dated 10/01/15 through 10/31/15 revealed an order for Oxycodone 15 mg (milligrams) by mouth every 6 hours as needed for pain. Review of medication admiration record (MAR) dated 10/01/15 through 10/31/15 indicated Resident #71 received Oxycodone 15 mg by mouth for pain on 10/21/15 and 10/22/15 but there was no documentation of the severity level of the pain or results or effectiveness of the medication on the back of the MAR. Interview with Nurse #3 on 10/22/15 at 6:02 PM indicated that she had worked third shift the previous night and confirmed that she had administered Oxycodone 15 mg by mouth on 10/22/15 to Resident #71 and that she got busy and forgot to document the pain severity or the effectiveness of the medication. She also confirmed that she had recently received education from the facility, and was aware that she needed to document the pain severity and effectiveness of the pain medication on the back of the MAR. She stated that she usually does this but got busy and just forgot. Interview with Director Of Nursing (DON) on 10/22/2015 at 11:59:09 AM confirmed that Nurse #3 had received the recent education provided by the facility on documenting the pain severity and effectiveness on the back of the MAR and indicated that she expected that all nurses document the severity of pain and within an hour of administration the effectiveness of the medication on the back of the MAR. 2. Resident #4 readmitted from acute care	{F 514}	On 10/30/15, the nurse practitioner evaluated the resident and wrote new orders dosing of scheduled pain medication. On 11/6/15, the nurse practitioner evaluated the resident's pain status for adequate control. No new orders given. On 10/22/15, the DON, treatment nurse and/or MDS nurse completed retraining for resident # 71's and resident # 4's nurses who did not document level of pain and/or effectiveness of prn pain medication. On 10/22/15, the DON, treatment nurse and/or MDS nurse completed an audit of documentation of other residents who had received prn medications for severity of pain and/or effectiveness of prn pain medication. No other occurrences were identified. On 10/28/15, the director of nursing (DON) initiated an in-service on "PRN Pain Documentation on the Back of the MAR". This in-service included the following: 1. All prn documentation of pain medication must match the front and back of the MAR. 2. Level of pain, location of pain, pain scale and effectiveness of pain must be documented on the back of the MAR. 3. Off-going nurse and on-coming shift nurses must check the back of the MARs for completeness. Any incomplete documentation will be corrected immediately by the off-going nurse. 4. Any concerns should be reported to the DON and/or administrative nurses. 5. Administrative nurses will be auditing prn	

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{F 514}	Continued From page 2 hospital on 07/15/15 with diagnosis of depression, diabetes mellitus, atrial fibrillation, and peripheral vascular disease. Review of most recent quarterly MDS dated 10/09/15 indicated that Resident #4 was cognitively intact with daily decision making and indicated that Resident #4 reported pain occasionally. Review of physician orders dated 10/01/15 through 10/31/15 revealed Percocet 7.5/325 mg (milligrams) take one tablet by mouth every 4 hours as need for pain. Review of MAR dated 10/01/15 thru 10/31/15 indicated that Resident #4 had received Percocet 7.5/325 mg by mouth on 10/21/15 at 1:45 PM but did not indicated whether the medication was effective or not. Review of facility's education record confirmed that Nurse #4 received the recent education on documenting the severity of pain and the effectiveness of pain medication on the back of the MAR that was provided by the facility recently in the last month. Several attempts to reach Nurse #4 who administered Percocet 7.5/325 mg on 10/21/15 at 1:45 PM were unsuccessful. Interview with Director Of Nursing (DON) on 10/22/2015 at 11:59:09 AM confirmed that Nurse #4 had received the recent education provided by the facility on documenting the pain severity and effectiveness on the back of the MAR and indicated that she expected that all nurses document the severity of pain and within an hour of administration the effectiveness of the	{F 514}	documentation. 6. Corrective action may occur for incomplete documentation. Current and future licensed nurses will not be allowed to work until in-servicing is completed. The in-servicing was completed on 11/9/15. On 11/10/15, directed in-service training on medication administration will be completed by a pharmacist from Jones Professional Services, with the following credentials-Pharm D, certified geriatric pharmacist (CGP), and adjunct professor with Wingate School of Pharmacy, for all licensed nurses and medication aides. Completion date of training will be completed by 11/11/15. Beginning 11/5/15, the treatment nurse and/or MDS will utilize the "Documentation of Pain Medication" audit tool to monitor for completion of documentation to include severity of pain with effectiveness on the MARs. The tool will be completed 5 times weekly x 2 weeks, 2 times weekly x 4 weeks, weekly x 2 weeks, then on a monthly basis ongoing to ensure compliance. The Director of Nursing will audit the "Documentation of Pain Medication" audit tool to ensure documentation of pain level and effectiveness of prn pain medications is completed. The documentation of pain medications reviewed will be indicated by the DON's initials. This audit will be completed 5 times weekly x 2 weeks, 2 times weekly x 4 weeks, weekly x 2 weeks, then on a monthly basis ongoing to ensure compliance. Any negative findings will be addressed immediately	

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{F 514}	Continued From page 3 medication on the back of the MAR.	{F 514}	with necessary changes being made. The findings of the "Documentation of Pain Medication" audit tool will be presented weekly to the QI committee during morning meeting on an ongoing basis until compliance is reached and sustained. The QI committee, consisting of the Administrator, DON, MDS nurse, Treatment Nurse, Dietary Services Manager, Housekeeping Laundry Supervisor, Maintenance Director, Social Worker and Admissions Coordinator will make recommendations, as necessary, regarding the outcomes of the audit. The findings of the morning meeting QI committee will be presented to the monthly Executive QI Committee, by the Administrator or DON, for review and for recommendations, as appropriate, to maintain continued compliance. The Executive QI committee includes the Medical Director, Administrator, DON, SW, MDS nurse and Treatment Nurse.	
{F 520} SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify	{F 520}		11/11/15

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{F 520}	Continued From page 4 issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in October of 2015. This was for one recited deficiency which was originally cited in September 2015 on a recertification survey and on the current follow up and complaint survey. The deficiency was in the area of complete and accurate medical records. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: F514 Complete and accurate medical records: Based on record review and staff interviews the	{F 520}	Magnolia Lane Nursing and Rehabilitation Center 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 the applicable rules and provision of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Magnolia Lane Nursing and Rehabilitation Center's response to this statement of deficiencies does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Magnolia Lane Nursing and rehabilitation Center reserves the right to refute any of the deficiencies on this statement of deficiencies through informal dispute resolution, formal appeal	

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{F 520}	Continued From page 5 facility failed to document severity of pain or response to pain medications for 2 of 5 residents (Resident #71 and Resident #4) that were sampled for documenting pain severity and effectiveness of pain medications. During the recertification survey of 09/11/15 the facility was cited for failure to document severity of pain or responses to pain medication for 1 of 3 residents sampled for pressure ulcers (Resident #53). On the current follow up and complaint survey the facility was cited again for failure to document severity of pain or response to pain medications for 2 of 5 residents (Resident #71 and Resident #4) that were sampled for documenting pain severity and effectiveness of pain medications. During an interview on 10/15/15 at 6:28 PM the Administrator explained a Quality Assessment and Assurance committee meeting was held on 09/25/15 and they reviewed the potential citations from the recertification survey they expected to receive. She stated the next meeting was scheduled for 10/30/15 and they had planned to discuss each citation and the audits that had been done to review their percentages of compliance for each citation. She explained nurses had been educated regarding documentation of pain severity and effectiveness of pain medication and the audits had reflected some improvement with documentation each week but there was still room for improvement. She further explained the audits had not included 100 percent of every Medication Administration Record every day so the plan they had implemented had not worked and they would have to change processes to fix it.	{F 520}	procedure and/or any other administrative or legal proceeding. F 520 QAA Committee-Members/Meet Quarterly Plans On 10/29/15, Alliant Quality Advisors completed a QIO in-service for department heads and hall nurses. The training included the following: 1. QAPI at a Glance-A Step by Step Guide to Implementing Quality Assurance and Performance Improvement (QAPI) in Your Nursing Home, 2. CHANGE PACKAGE-A curated collection of great ideas & practices to create lasting change in your nursing home. 3. QAPI Process Tool Framework. On 10/30/15, an Executive QI meeting was held which included the Accounts Receivable Manager, Housekeeping Laundry Supervisor, Medical Director, Maintenance Supervisor, Dietary Manager, DON, MDS nurse, Treatment Nurse, Consultant Pharmacist, and Administrator. The plan of correction, re-survey visit, and the new tag were reviewed and minutes were taken. On 11/10/15, directed in-service training on medication administration will be completed by a pharmacist from Jones Professional Services, with the following credentials-Pharm D, certified geriatric pharmacist (CGP), and adjunct professor with Wingate School of Pharmacy, for all licensed nurses and medication aides. Completion date of training will be 11/11/15.	

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{F 520}	Continued From page 6	{F 520}	Beginning 11/5/15, weekly QI meetings will be held in morning meeting to review compliance for F 333 Resident Free of Significant Med Errors and F 514 Resident Records-Complete/Accurate/Accessible. All findings will be reviewed from the audit tools for any compliance issues with recommendations to correct and/or sustain continued compliance. All findings from the weekly QI meetings will be reviewed by the Executive QI committee monthly to ensure the facility maintains implemented procedures and monitors these interventions for continued compliance.	

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F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview the facility failed to prevent significant medication error by administering the incorrect dose of blood pressure medication (Cozaar) for high blood pressure for 1 of 1 of residents (Resident #26) sampled for unnecessary medications. The findings include: Resident #26 was readmitted to the facility on 05/04/2015 with diagnosis that included hypertension. Review of Resident #26's hospital discharge summary dated 05/04/15 included an order for Cozaar 50 milligrams (mg) take 2 tablets by mouth daily for hypertension. Review of the most recent quarterly Minimum Data Set (MDS) dated 09/26/15 revealed that Resident #26 was cognitively intact for daily decision making. Review of the monthly physician's order sheet dated 10/01/15-10/31/15 contained an order for Cozaar 50 mg take 2 tablets by mouth daily at 8:00 AM and 8:00 PM. Review of Resident #26's Medication Administration Record (MAR) dated 10/01/15	F 333	F 333 Resident Free of Significant Med Errors On 10/22/15, Resident # 26 was assessed including his vital signs by the assigned hall nurse. The director of nursing also assessed the resident's vital signs. The resident expressed no complaints. No concerns were identified. On 10/22/15, the physician of Resident # 26 was notified of the incorrect dosing of the Cozaar. A new order for Cozaar 100mg by mouth daily was obtained from the attending physician. The new order was correctly transcribed onto the MAR per the physician order. The DON verified that the dose of the blood pressure medication on the physician's order matched the MAR dosage and administration times. On 10/22/15, 100% audit of all MARs were completed by the DON, MDS Coordinator and Treatment nurse to ensure that all times printed on the MAR matched the written physician order, to ensure residents received the correct dosage of medication. No other concerns were identified. On 10/22/15, the Director of Nursing and	11/11/15

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Electronically Signed | 11/06/2015

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F 333	Continued From page 1 through 10/31/15 included Cozaar 50 mg take 2 tablets by mouth daily at 8:00 AM and 8:00 PM. It had been signed out by nursing twice a day instead of once a day each day for the month of October. Review of Resident #26's blood pressure log for the month of October 2015 revealed a blood pressure was obtained on 10/22/15 and was noted to be 114/64. Observation of Medication Aide #1 on 10/22/15 at 9:45 AM revealed Med Aide #1 pulled Resident #26's medications from the drawer for administration. There was a box of Cozaar with Resident #26's name on it that stated 50 mg take 2 tabs equal to 100 mg by mouth daily. Instructions printed on the box indicated "note dose." Interview with Med Aide #1 on 10/22/15 at 9:45 AM confirmed that she gave Resident #26 2 50 mg tablets of Cozaar as stated on the MAR. Interview with Nurse #1 on 10/22/15 at 10:09 AM revealed that she was the nurse responsible for overseeing Med Aide #1 and confirmed the initials on the MAR meant 100 mgs of Cozaar was given twice a day instead of once a day. On 10/22/15 at 10:19 AM, Nurse #1 explained to the Director of Nursing (DON) and Nurse #2, that two 50 mg tablets of Cozaar had been administered twice a day to Resident #26. The DON sent Nurse #1 to check Resident #26's blood pressure and heart rate. Nurse #1 returned at 10:22 AM and indicated Resident #26's blood pressure was 114/64 and heart rate was 74. The DON confirmed that the staff were incorrectly	F 333	Treatment Nurse initiated in-servicing of Licensed Nursing Staff and Medication Aides on “Medication Administration”. The “Medication Administration” in-service included: 1. Medication administration times must be transcribed correctly on the Medication Administration Record (MAR), 2. Read each medication order on the MAR prior to administering medication to resident. Ensure that the order and times match, 3. Month end MAR checks-first check to be completed by a staff nurse, 2nd check to be completed by a hall nurse and administrative nurse and/or the DON. The nurse will report any errors should be reported immediately, corrected, and clarified with the physician as applicable. 4. Any concerns should be reported to the DON or administrative nurses. Licensed nurses or medication aides will not be allowed to work until in-service is completed. The in-servicing was completed on 11/9/15. All future new licensed nurses and medication aides will be in-serviced upon hire. On 11/10/15, directed in-service training on medication administration will be completed by a pharmacist from Jones Professional Services, with the following credentials- Pharm D, certified geriatric pharmacist (CGP), and adjunct professor with Wingate School of Pharmacy, for all licensed nurses and medication aides. Completion date of training is 11/11/15. Beginning 11/5/15, the Treatment Nurse or MDS Nurse will review 75% of new medication orders 5 times weekly x 2 weeks, 2 times weekly x 4 weeks, weekly	

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F 333	Continued From page 2 administering 100 milligrams of Cozaar twice a day to Resident #26 as indicated on the resident's MAR. Interview with DON on 10/22/15 at 10:46 AM revealed that when a resident is admitted or readmitted to facility to the facility the physician orders are reviewed and called to the doctor who verifies the medications are acceptable. The nurse then writes a new MAR and a second nurse checks to make sure the medications are transcribed correctly. Then orders are faxed to the pharmacy for the medications to be delivered to the facility. She further stated that each month the MAR's are reviewed not once but twice for accuracy. She stated she expected that any error or discrepancy would be caught during these two checks at the end of the month. She also stated the pharmacy checks the MAR's monthly and would expect them to catch anything that the nurses missed. Interview with the physician assistant on 10/22/15 at 11:04 AM revealed that he would expect a medication that was ordered once a day to be given once a day and not twice a day. He confirmed that no labs were needed at this time and the biggest concern was to monitor Resident #26's blood pressure now that he was only getting the medication once a day instead of twice a day. Interview with Medical Doctor on 10/22/15 at 11:09 AM revealed he was not aware of this medication error for Resident #26 and he would expect a medication that was ordered once a day to be given only once a day. He did not believe that there was any negative outcome for Resident #26 and the biggest concern would be to monitor his blood pressure now that he was receiving the	F 333	x 2 weeks, then on a monthly basis ongoing to ensure correct transcription. This review will be documented on the "New Medication Review" audit tool. The "New Medication Review" audit tool will be given to the Director of Nursing. The Director of Nursing will audit 50% of the new medication orders recorded on the "New Medication Review" audit tool to ensure correct transcription. The new medication orders reviewed will be indicated by the Director of Nursing's initials. This audit will be completed 5 times weekly x 2 weeks, 2 times weekly x 4 weeks, then on a monthly basis ongoing to ensure correct transcription. Any negative findings will be addressed immediately with necessary changes being made. The findings of the "New Medication Review" audit tool will be presented weekly to the QI committee during morning meeting on an ongoing basis until compliance is reached and sustained. The QI committee, consisting of the Administrator, DON, MDS Nurse, Treatment Nurse, Dietary Services Manager, Housekeeping Laundry Supervisor, Maintenance Director, Social Worker and Admissions Coordinator, will make recommendations, as necessary, regarding the outcomes of the audit. The findings of the morning meeting QI committee will be presented to the monthly Executive QI Committee, by the Administrator or DON, for review and for recommendations, as appropriate, to	

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MAGNOLIA LANE NURSING AND REHABILITATION CENTER	107 MAGNOLIA DRIVE MORGANTON, NC 28655

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F 333	Continued From page 3 medication once a day instead of twice a day. He stated no lab work was needed at this time and the biggest concern now would be to monitor his blood pressure. An interview on 10/22/15 at 11:31 AM with facility's pharmacy consultant revealed that she visited the facility once a month and that she was very familiar with Resident #26. She stated that when a resident was admitted or readmitted to the facility the physican orders are verified at facility and then faxed to the pharmacy. Once the orders are received at the pharmacy, staff enters the orders into the system and the pharmacist checks the orders that have been inputted by pharmacy staff. After the pharmacist has verified the information the medications are filled and delivered to the facility. The pharmacy consultant stated that it is the expectation that the nurses will verify the medication label that is delivered to facility from the pharmacy to the MAR upon delivery and before placing the medication on the medication cart for use. She further stated that she visited the facility once a month, during these visits she stated she would check resident's admission or readmission orders against the resident's MAR and make sure they matched and looked for proper monitoring of medications, for example if they are on a blood pressure medication are vital signs being taken as ordered. She confirmed that she had not made any recommendations for Resident #26 regarding the blood pressure medication. She also confirmed that she did not recall looking at Resident #26's MAR and seeing the medication was being administered twice a day instead of once a day. She stated that Resident #26's physician's order sheet that was faxed to pharmacy was hand written incorrectly and that was the way the	F 333	maintain continued compliance. The Executive QI committee includes the Medical Director, Administrator, DON, SW, MDS nurse and Treatment	

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 10/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 333	Continued From page 4 pharmacy printed them.	F 333		