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| E 000 | Initial Comments<br><br>An unannounced Recertification survey was conducted on 07/31/23 through 08/03/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 94Q011. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced recertification survey was conducted from 07/31/23 through 08/03/23. Event ID# 94Q011. | F 000 | | |
| F 689 SS=G | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff, resident, and Medical Director interviews the facility failed to assist a resident with a transfer from the wheelchair to bed when Nurse Aide (NA) #1 stood behind Resident #4 and allowed the resident to transfer independently. Resident #4's leg slipped, the resident fell onto the bed and experienced shoulder pain. Resident #4 sustained a left humeral head fracture of the shoulder as was noted on the CT (computed tomography) scan on 7/20/2023. This was for 1 of 3 residents reviewed for supervision to prevent accidents.<br><br>The findings included: | F 689 | 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 applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Magnolia Lane Nursing and Rehabilitation□s response to this statement of deficiencies does not denote agreement with the statement of | 8/21/23 |

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

Electronically Signed | 08/17/2023

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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| F 689 | Continued From page 1<br><br>Resident #4 was admitted to the facility on 6/19/2023. Her diagnoses included chronic obstructive pulmonary disease (COPD), primary osteoarthritis of the left shoulder, stroke, atrial fibrillation, and left hemiplegia.<br><br>Review of the physician orders for Resident #4 included Apixaban (blood thinner) 5mg (milligrams) by mouth twice a day for Atrial Fibrillation. Ordered 6/19/2023.<br><br>A review of the physical therapy evaluation conducted on 6/21/2023 by the Physical Therapist revealed Resident #4's prior level of skill for transfers from bed to chair before 6/23/23 was "modified independence, assistive device or extra time needed," to current level of assistance after the incident on 6/23/23 was documented as "moderate assist, 26-75% assistance."<br><br>Review of the facility incident report dated 6/23/2023 at 8:00 PM revealed NA #1 went to offer stand-by assist to resident (Resident #4). NA #1 stood behind resident's wheelchair, after positioning resident's wheelchair to the side of the bed with the wheels locked. Resident was dressed and had on sneakers. Resident used her right hand to pull herself up into a standing position with the bed rail. Resident's foot began to slide out and NA #1 went around the wheelchair and was unable to prevent the resident from falling onto the bed onto her left side. Resident landed on the mattress only. Bedroom lights were on, and the room was free from clutter. Resident had decreased range of motion to her left arm and shoulder and reported pain of 6/10. The on call provider was notified and orders for x-ray of left shoulder two views. Standing order for Tylenol | F 689 | deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Magnolia Lane Nursing and Rehabilitation reserves the right to refute any of the deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding.<br><br>F689 Free of Accident Hazards/ Supervision/ Devices<br>¿ On 6/23/2023 Resident #4 was transferring to bed with NA #1 standing behind the wheelchair. Resident #4 lost balance and went forward onto the bed. Resident #4 was assessed by Nurse #1 and had no initial signs of injury or change in complaints of pain. Nurse #1 provided Tylenol via standing order and Resident #4 slept through the night with no complaints of pain. On 6/24/2023, the Director of Nursing (DON) notified the Medical Director (MD) of the incident and an x-ray was ordered that came back negative. On 7/24/2023, related to continued pain in left shoulder, a CT Scan was done results showed incomplete healing left humeral head and surgical neck fracture. MD notified, Resident #4 notified, Resident Representative notified, and an order from the MD was received for consult with Emerge Ortho. A sling for the left arm for comfort was ordered, Incident Report prepared and full investigation initiated.<br>¿ On 7/24/2023, the DON re-educated NA #1 regarding proper transfer technique and reporting. On 7/24/2023, the DON and Assistant Director of Nursing (ADON) | |

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| F 689 | Continued From page 2<br>initiated and new order for Norco 5-325mg (narcotic pain medication) give one by mouth every 6 hours as needed for moderate pain. Signed by the Director of Nursing.<br><br>Review of the physician order's for Resident #4 revealed an order for a left shoulder, two view x-ray dated 6/24/2023.<br><br>Review of the x-ray report dated 6/24/2023 revealed:<br>Severe degenerative changes of the gleno-humeral (head of the humerus that contacts the glenoid cavity or fossa of the scapula (shoulder blade) joint. No obvious fracture as best can be determined due to limitations. Short follow-up exam is recommended. CT (computed tomography is a diagnostic scan that used a combination of x-rays and computer technology to produce images of the inside of the body) should be considered if there is high suspicion for fracture.<br><br>Review of Resident #4's admission Minimum Data Set (MDS) dated 6/28/2023 revealed Resident #4 was cognitively intact and required one-person extensive assist with transfers. She was coded for balance as not steady, only able to stabilize herself with staff assistance, and transfers as not steady, only able to stabilize herself with staff assistance for surface-to-surface transfer (transfer between bed and chair or wheelchair).<br><br>Further review of Resident #4's medical record revealed Tylenol Arthritis 8-hour ER (extended release) 650mg was ordered by mouth three times a day for shoulder pain on 6/28/2023 and Norco 5-325mg was ordered by mouth every six | F 689 | completed an audit of all residents that have one sided weakness and are minimum assistance or stand by assist to ensure the appropriate transfers were identified on the care plan and the care guide. Therapy referrals were completed during the audit as needed. On 7/25/2023, the Nurse Consultant in-serviced the Interdisciplinary Team (IDT) to include the Administrator, DON, ADON, Minimum Data Set (MDS) Nurse, Social Worker and Therapy Manager to ensure appropriate transfer information is passed on to the floor staff upon admission or change in condition of a resident.<br>¿ On 7/28/2023, the Administrator and the Staff Development Coordinator Nurse (SDC) began in-servicing Certified Nurse Aides and Nurses on how to properly assist with transfers by standing in a location that would maximize their ability to offer assistance as needed and to ensure they were checking and following the care guide to use appropriate transfer method and eliminate risk for falls. Education was completed by 7/31/2023. Beginning 8/1/2023, this training will be provided to all new hires and agency nursing staff during orientation.<br>¿ The DON will review new admissions and residents with a change in condition during the IDT meeting to ensure appropriate transfer and assistance that is needed by staff is identified on the care plan and care guide. The MDS Nurse will update care plan and care guide as appropriate. The DON and SDC Nurse will oversee 3 resident transfers including residents with hemiplegia and one-sided | |

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| F 689 | Continued From page 3<br>hours as needed for pain on 7/12/2023.<br><br>Review of the care plan dated 7/13/23 for Resident #1 revealed the following care areas:<br><br>ADL self-care deficit related to history of CVA with left side hemiplegia. Initiated 6/27/23. Interventions included assist resident with showers and baths, and assist resident with ADL care, resident is an extensive assist of one person.<br><br>Fallls related to left sided hemiplegia. Initiated 7/13/23. Interventions included: fall mat beside bed when resident in bed and education of resident on calling for assistance before transfers.<br><br>A review of the Medical Director progress note dated 7/17/2023 revealed: Resident #4 has had chronic shoulder pain bilaterally: left worse than right. She had a fall into the bed, getting into the bed in late June; initial evaluation appeared to be a fall with contusion (bruise), bruising and exacerbating the left chronic shoulder arthritis; She was on anticoagulant for A Fib (atrial fibrillation) which led to increased bruising and ecchymosis (a discoloration under the skin resulting from bleeding underneath, typically caused by bruising) of the left upper arm. Concern for some bleeding in the muscle as well. Pain meds were adjusted, and she has had some improvement, however, pain seems to be persisting despite bruising in stages of resolution: will repeat x-rays and CT at hospital.<br><br>Review of the CT scan dated 7/20/23 of Resident #4's upper left extremity without contrast revealed: | F 689 | weakness and review the care plan and care guide weekly X 4 weeks using the Transfer Audit Tool. Staff will be retrained during the audit with any identified areas of concern. Results of audit will be shared with Quality Assurance Performance Improvement (QAPI) members monthly x 1 month or until a time determined by the QAPI members for sustained compliance.<br>¿ Alleged date of compliance is 7/31/2023 | |

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Incomplete healing of the left humeral head and surgical neck fracture.
Advanced glenohumeral joint osteoarthritis.
Acromioclavicular joint (one of four joints that forms the shoulder complex) osteoarthritis.

An interview was conducted with Resident #4 on 8/1/2023 at 8:10 AM: Resident #4 stated she remembered the incident where she fell onto her bed and hurt her left shoulder. She revealed, "I don't really know what happened, I was getting up out of my wheelchair, we locked my wheelchair wheels, the Nurse Aide was behind my chair, when I stood up, my foot slid, I lost my balance and fell onto the bed. I landed on my left shoulder. The Nurse Aide yelled for help and the Nurse came in and checked me out. My shoulder hurt so she gave me some Tylenol and some other pain medicine and my shoulder felt better." She indicated she had an x-ray of her shoulder the next morning.

A follow up interview was conducted with Resident #4 on 8/2/2023 at 2:28 PM. Resident #4 stated that staff did not help her with transfers, she transferred herself. She revealed she did not feel she needed assistance to transfer because she could transfer herself. She clarified and stated staff "do not use a gait belt or any type of hands-on assistance for transfers before or and after the fall."

An interview was conducted with Nurse Aide (NA) #1 on 8/1/2023 at 4:00 PM. She stated she was the NA that was assigned to Resident #4 on 6/23/2023 when she fell and hurt her left shoulder and it was the first time she had been assigned to Resident #4. The fall happened around bedtime. Resident #4 was starting to get into bed by

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herself. NA #1 went into assist her by standing behind the wheelchair. NA #1 stated she grabbed the back of Resident #4's pants when her left foot started to slide, and resident started to fall onto the bed. Resident #4 lost her balance and fell onto the mattress onto her left shoulder. NA #1 stated that to her knowledge, Resident #4 only hit the mattress and did not hit the footboard. After she fell onto the bed, she was half on and half off the bed, NA #1 used the draw sheet to pull Resident #4 onto the bed completely. Resident #4 was complaining of pain, so she went and notified Nurse #1 and Nurse #1 came in and assessed Resident #4 and to her knowledge, did not find any injuries. NA #1 stated that she would check the shift report to see how to a resident was to be transferred. She stated she would not normally check the resident's care guide (guide in the computer that instructed the aides on how to care for the resident, to include resident's transfer status) to see how a resident was to be transferred. She stated she was told by another NA, but does not remember who told her, that Resident #4 could transfer by herself. She stated she received training from the Director of Nursing after the incident for the proper way to transfer a resident. NA #1 revealed she should have checked the resident care guide prior to transferring Resident #4, so she would know what level of assistance the resident needed.

A telephone interview was conducted with Nurse #1 on 8/1/2023 at 7:42 PM. Nurse #1 stated she was the nurse assigned to Resident #4 on 6/23/2023 when she fell and hurt her left shoulder. She revealed that NA #1 had told her that she had been helping Resident #4 get into the bed around 7:30-8:00 PM, when she fell onto the bed. Nurse #1 stated she went to check on

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Resident #4 and she was "complaining of some pain in her left shoulder, but she did sleep all night and really did not fuss that much about pain." Nurse #1 stated she could not remember what level of pain Resident #4 had on the pain scale, but she was hurting worse the next morning. The Director of Nursing relieved Nurse #1 on the medication cart the morning of 6/24/2023 and the Director of Nursing called the on-call provider and got an order for an x-ray and pain medication. She revealed she did not give Resident #4 anything for pain after the incident except for Tylenol that was already scheduled. Nurse #1 indicated she did not call the on-call provider about the fall on the night of 6/23/2023 because she did not feel like the resident fell, because landing on the bed did not mean the resident fell and the resident did not appear to be in more pain than usual. Nurse #1 stated she did not remember what transfer status Resident #4 was when she fell, but that NA #1 should have checked the resident care guide if she was unfamiliar with the resident or did not know how to transfer Resident #4. The care guide for each resident is located on the Kiosk (computer on the wall). She revealed she did not put an intervention in place, to help prevent further falls, after the incident, because she did not feel like Resident #4 had a fall, "she just lost her balance." She stated that should have put an intervention in place as she now understood that Resident #4 did have an actual fall.

An interview was conducted with NA #2 on 8/2/2023 at 1:10 PM. NA #2 stated she was familiar with Resident #4 and that she was cognitively intact and able to follow instructions. She revealed that Resident #4 had a lot of pain in her left shoulder, she did not complain daily, but

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did complain to her about pain before and after the fall. She notified her assigned nurse so pain medication could be given. NA #2 stated she transferred Resident #4 with a gait belt around her waist, then guide her for the transfer. She revealed this was how she transferred Resident #4 prior to her fall and now her transfer status had been changed after the fall to two-person physical assist with transfers. She stated that Resident #4 was able to stand up and have the gait belt around her waist, she (NA) would then hold on to the back of the gait belt to give Resident #4 some support and helped guide her onto the bed or her wheelchair. NA #2 indicated that Resident #4 was a 1-person physical assist which meant the resident needed a staff member to put their hand on the resident to assist with the transfer. NA #2 revealed if she was unfamiliar with a resident's transfer status, she would check the resident care guide, "it tells you everything you need to know about how to take care of the resident."

An interview was conducted with NA #3 on 8/2/2023 at 1:19 PM: NA #3 revealed Resident #4 was and extensive assist for transfers with a one-person physical assist. He revealed he transferred Resident #4 this way prior to the fall and after the fall, she had been changed to two-person physical assist for transfers. He stated he used a gait belt to support Resident #4 when she stood to transfer, but he assisted her by touching her, guiding her, and supporting her during the transfer. NA #3 revealed that each resident had a care guide that told the staff how to care for that resident, it included how they eat, transfer, bed mobility, how they moved around the facility and if they needed specific equipment or had special needs. He stated that Resident #4

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was unsteady on her feet from her stroke.

An interview was conducted with the Physical (PT) Therapy Director: She stated that all falls were reviewed by therapy to determine if therapy was needed. She revealed that Resident #4 was on the therapy caseload when she fell on 6/23/2023. PT stated it was her understanding that there was some confusion originally after the fall because the staff were trying to determine if Resident #4 had an actual fall or not, since she lost her balance and fell onto the bed. She stated that Resident #4 was cognitively intact, and she was re-educated on not trying to transfer herself, but to ask staff for assistance. PT stated that at the time of the fall, Resident #4 was a physical assist of one person for transfers and that the NA should have physically assisted by putting her hands on the resident during the transfer and used a gait belt. She stated she was unaware at the time of the fall that Resident #4 had been transferring herself instead of calling for assistance.

An interview was conducted with the Medical Director (MD) on 8/2/2023 at 10:09 AM. He stated that Resident #4 had severe osteoporosis, and bilateral shoulder capsulitis (also known as frozen shoulder, an inflammatory condition characterized by shoulder stiffness, pain, and significant loss of passive range of motion (when a therapist caused the movement of a joint), worse on the left from the right. He revealed that with her severe osteoporosis, that it would not take much force for a bone to break. The MD stated he was trying to give her some time to heal and treat her conservatively, because there were days that she had good days with her left hemiplegia and did not have as much pain. She had chronic daily

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pain from her osteoarthritis. The Medical Director explained that Resident #4 was also on a blood thinner, Eliquis, and when she fell, she had extensive bleeding into the muscle. He revealed he did not stop the Eliquis, after the fall, because the risk of not taking he Eliquis for her Atrial Fibrillation was worse than the side effects. He revealed that Resident #4's shoulder injury was worse than he had originally thought, he had thought maybe a hair line fracture, but it was an impacted (a fracture where the broken ends of the bone are jammed together by the force of the injury. The MD revealed when he became aware of the incident, he adjusted her pain medication several times. He indicated he had to talk Resident #4 into having the CT exam, because she did not want to have surgery. He stated he believed now that she had hit the footboard with her shoulder instead of just hitting the soft mattress. He stated he did not feel it was an issue to wait so long to obtain a CT exam because he was trying to manage her conservatively.

An interview was conducted with the Director of Nursing (DON) on 8/2/2023 at 9:27 AM. She stated she became aware of Resident #4's fall on 6/24/23 when she relieved Nurse #1 on the medication cart. The DON stated the Nurse should have called the medical provider on call at the time of the fall for further instructions. The DON stated that each resident has a care guide that details what was needed to take care of the resident, how they transfer was included on the care guide. She indicated that NA #1 had worked at the facility previously and had been trained on how to use the care guide and she was also trained again during her orientation for this employment. The DON stated that Nurse #1 told her in report the morning of 6/24/2023 that

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| 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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| F 689 | Continued From page 10<br>Resident #4 had slipped when transferring back to bed and landed on the mattress of the bed. Nurse #1 told her that she gave Resident #4 some Tylenol but that she really did not complain of pain too much during the night. Resident #4 was now complaining of more pain, so the DON called the on-call provider for further instructions. She gave her some pain medication and ordered an x-ray of her left shoulder. She indicated that the Medical Director was monitoring her and since she continued to complain of pain and her range of motion was worse that we would order a CT scan. The CT scan was completed on 7/20/2023 and when we got the results back, she called the MD and notified him that Resident #4's shoulder was broken. He gave her an order for send to the orthopedist. | F 689 | | |