| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345520 | A. BUILDING _____ B. WING _____ | C 05/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB | 1028 BLAIR STREET THOMASVILLE, NC 27360 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>An unannounced complaint investigation was completed from 05/08/24 through 05/09/24. Additinal The following intake was investigated: NC00216352. 2 of the 7 allegations resulted in deficiency. Additional information was obtained offsite on 05/21/24. Therefore, the exit date was changed to 05/21/24. See # 65CN11. | F 000 | | |
| F 550 SS=E | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. | F 550 | | 6/11/24 |

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

Electronically Signed | 05/28/2024

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345520 | A. BUILDING _____ B. WING _____ | C 05/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB | 1028 BLAIR STREET THOMASVILLE, NC 27360 |

| (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 550 | Continued From page 1<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observations, resident, and staff interviews the facility failed to provide care in a manner to maintain the resident ' s dignity by not answering call bells for residents that need extensive assistance with activities of daily living (ADLs). This was evident for 3 of 6 residents (Resident #10, Resident #3, and Resident #4) reviewed for dignity.<br><br>Findings include:<br><br>1. Resident #10 was admitted to the facility on 11/15/23 with diagnoses that included chronic obstructive pulmonary disease (COPD), rheumatoid arthritis, diabetes mellitus, and osteoarthritis of right knee.<br><br>Review of the quarterly Minimum Data Set (MDS) dated 04/22/24 revealed Resident #10 ' s cognition was intact. She required moderate assistance with toileting, shower/baths, and personal hygiene. She required maximum assistance with dressing and was dependent on staff for transfers. She was always incontinent of bowel and bladder. | F 550 | F550<br>1. Resident #10, #3, and #4 call lights were confirmed to be in place on May 9, 2024 by the Administrator. The Administrator conducted random call light response checks on resident #19, #3, and #4 to confirm the call light response time was not excessive on May 10, 2024. All residents have potential to be affected.<br><br>2. An audit was completed on May 10, 2024, by the Administrator or designee of the current residents to ensure call light response time was appropriate and audit revealed that all call light were answered in the appropriate amount of time.<br><br>3. All associates will receive education that they must answer a call light and that training will include answering call lights that are not on your assignment by May 31, 2024 by Administrator or designee.<br><br>4. The Administrator or designee will complete audits of at least 8 residents | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345520 | A. BUILDING _____ B. WING _____ | C 05/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB | 1028 BLAIR STREET THOMASVILLE, NC 27360 |

| (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 550 | Continued From page 2<br><br>An interview on 05/08/24 at 10:21 AM with Resident #10 was conducted. She stated she had waited up to 2 hours for her call light to be answered, which resulted in her sitting in urine and bowel movement. She indicated she did not want to sit in a soiled brief. She did not recall the dates of the occurrences. She then stated she can time how long the call light had been on according to what she ' s watching on TV at the time.<br><br>Resident Council minutes reviewed for 09/07/23, 10/03/23, 11/02/23, and 01/04/24 revealed concerns related to Nursing Assistants (NAs) not providing activity of daily living (ADL) care. On 12/07/23, 02/08/24, 03/07/24, and 04/24/24 concerns related to Nursing Assistants (NAs) call light response time were voiced.<br><br>An interview was conducted on 05/09/24 at 1:08 PM with the Assistant Director of Nursing (ADON). The ADON stated she did pull NA #1 to assist with transportation during the morning of 05/09/24 and she made the nurses and other NAs know she would be off the hall. She stated the other NAs on the hall would assist in covering the section until the NA returned.<br><br>An interview was conducted on 05/09/24 at 1:10 PM with the Director of Nursing (DON). The DON stated she was unaware of the wait times and staff not answering call bells. She also stated her expectations is for the call lights to be answered in a timely manner by all staff.<br><br>2. Resident #3 was admitted to the facility on 03/26/21 with diagnosis that included Parkinson ' s Disease, diabetes mellitus, and Dementia. | F 550 | weekly for 4 weeks and monthly for 2 months to ensure resident has an appropriate call light response time.<br><br>5. The Administrator or designee will report findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting for at least 3 months for review to ensure compliance.<br><br>Date of Compliance: June 11, 2024 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345520 | A. BUILDING _____ B. WING _____ | C 05/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB | 1028 BLAIR STREET THOMASVILLE, NC 27360 |

| (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 550 | Continued From page 3 | F 550 | | |

Review of the admission Minimum Data Set (MDS) dated 04/24/24 revealed Resident #3 cognition was moderately impaired. She required set-up/clean-up assistance with toileting, minimal assistance with eating, oral hygiene, and personal hygiene. She also required moderate assistance with shower/baths and dressing. She had limited range of motion (ROM) to one side of her upper extremities.

A continuous observation and interview on 05/09/24 from 9:44 AM through 10:13 AM revealed call lights were activated. Nursing Assistant (NA) #2 was noted sitting at the nurses ' station in front of the computer. NA #2 was asked if she was aware the call lights were activated and she stated, "They ' re not my residents" and then stated, "I thought that nursing assistant had returned to the hall". She indicated she normally answered any call lights that were activated, and she should not have assumed NA # 1 was going to do so.

An interview was conducted on 05/09/24 at 11:40 AM with Nursing Assistant (NA) #1. She verified she was the direct care Nursing Assistant (NA) for Resident #3 ' s room. She stated she answered the call bells as timely as she could however this morning she had been pulled to assist with transportation and was not on the floor for a period of time. She stated the nurses and other NAs knew she would be off the hall for transportation. She stated she did not tell other staff she was leaving her assignment, but the ADON was on the floor, and she did.

Resident Council minutes reviewed for 09/07/23, 10/03/23, 11/02/23, and 01/04/24 revealed

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345520 | A. BUILDING _____ B. WING _____ | C 05/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB | 1028 BLAIR STREET THOMASVILLE, NC 27360 |

| (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 550 | Continued From page 4 | F 550 | | |

concerns related to Nursing Assistants (NAs) not providing activity of daily living (ADL) care. On 12/07/23, 02/08/24, 03/07/24, and 04/24/24 concerns related to Nursing Assistants (NAs) call light response time were voiced.

An interview was conducted on 05/09/24 at 1:08 PM with the Assistant Director of Nursing (ADON). The ADON stated she did pull NA #1 to assist with transportation during the morning of 05/09/24 and she made the nurses and other NAs know she would be off the hall. She stated the other NAs on the hall would assist in covering the section until the NA returned.

An interview was conducted on 05/09/24 at 1:10 PM with the Director of Nursing (DON). The DON stated she was unaware of the wait times and staff not answering call bells. She also stated her expectations is for the call lights to be answered in a timely manner by all staff.

An interview was conducted on 05/09/24 at 1:55 PM with Resident #3. She revealed that when she activated her call light to request assistance on 05/09/24 at about 09:45 AM, it took staff 30 minutes to come to her room. She did not recall why she activated the call light at that time. She indicated she often had to wait up to an hour for help after she activated the call light. She also stated she got frustrated and helpless when staff do not respond timely. She further stated it doesn ' t feel good to be wet that long. She indicated when the State was in the building, the staff answered the call bell a lot faster than if they were not.

3. Resident #4 was admitted to the facility on 09/21/23 with diagnoses that included heart

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345520 | A. BUILDING _____ B. WING _____ | C 05/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB | 1028 BLAIR STREET THOMASVILLE, NC 27360 |

| (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 550 | Continued From page 5 | F 550 | | |

failure, chronic obstructive pulmonary disease (COPD), difficulty walking, history of falls, and unsteadiness on feet.

Review of the quarterly Minimum Data Set (MDS) dated 04/25/24 revealed Resident #4 ' s cognition was intact. She required set-up/clean-up assistance with toileting, personal hygiene, and dressing. She required minimal assistance with showing/bathing and was occasionally incontinent of bladder.

A continuous observation and interview on 05/09/24 from 9:44 AM through 10:13 AM revealed call lights for rooms 214 and 216 were activated. Nursing Assistant (NA) #2 was noted sitting at the nurses ' station in front of the computer. NA #2 was asked if she was aware the call lights were activated and she stated, "there not my residents" and then also stated, "I thought that NA had returned to the hall". She indicated she normally answered any call lights that were activated, and she should not have assumed NA # 1 was going to do so.

An interview was conducted on 05/09/24 at 11:40 AM with Nursing Assistant (NA) #1. She verified she was the direct care Nursing Assistant (NA) for rooms 214 and 216. She stated she answered the call bells as timely as she could however this morning she had been pulled to assist with transportation and was not on the floor for a period of time. She stated the nurses and other NAs knew she would be off the hall for transportation. She stated she did not tell other staff she was leaving her assignment, but the ADON was on the floor, and she did.

Resident Council minutes reviewed for 09/07/23,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345520 | A. BUILDING _____ B. WING _____ | C 05/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB | 1028 BLAIR STREET THOMASVILLE, NC 27360 |

| (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 550 | Continued From page 6<br>10/03/23, 11/02/23, and 01/04/24 revealed concerns related to Nursing Assistants (NAs) not providing activity of daily living (ADL) care. On 12/07/23, 02/08/24, 03/07/24, and 04/24/24 concerns related to Nursing Assistants (NAs) call light response time were voiced.<br><br>An interview was conducted on 05/09/24 at 1:08 PM with the Assistant Director of Nursing (ADON). The ADON stated she did pull NA #1 to assist with transportation during the morning of 05/09/24 and she made the nurses and other NAs know she would be off the hall. She stated the other NAs on the hall would assist in covering the section until the NA returned.<br><br>An interview was conducted on 05/09/24 at 1:10 PM with the Director of Nursing (DON). The DON stated she was unaware of the wait times and staff not answering call bells. She also stated her expectations is for the call lights to be answered in a timely manner by all staff.<br><br>An interview was conducted on 05/09/24 at 1:45 PM with Resident #4. She revealed that when she activated her call light to request assistance on 05/09/24 at about 09:45 AM, it took staff 30 minutes to come to her room. She indicated she needed ice at that time, but it should not matter what the need was. She then stated it made her mad and upset when staff are heard talking about personal things, but they wouldn ' t answer the call light. | F 550 | | |
| F 558 SS=D | Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)<br><br>§483.10(e)(3) The right to reside and receive services in the facility with reasonable | F 558 | | 6/11/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345520 | A. BUILDING _____ B. WING _____ | C 05/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB | 1028 BLAIR STREET THOMASVILLE, NC 27360 |

| (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 558 | Continued From page 7<br>accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, resident interviews, and staff interviews, the facility failed to place a resident's call light (Resident #5 and #7) within reach to allow for the residents to request staff assistance this was for 2 of 3 residents reviewed for accommodation of needs.<br><br>The findings included:<br><br>1. Resident #7 was admitted to the facility on 03/19/20 with diagnosis that included epilepsy and epileptic syndromes, history of falls, traumatic brain injury and traumatic subdural hemorrhage with loss of consciousness.<br><br>The annual Minimum Data Set (MDS) assessment dated 02/10/24 indicated Resident #7 ' s cognition was severely impaired. He had no behavior and no rejection of care. He required minimum assistance of 1 for toileting hygiene and personal hygiene and required maximum assistance with shower/baths. He was occasionally incontinent of bladder and always continent of bowel. He had no functional limitation with range of motion of her extremities.<br><br>Resident #5's active care plan, last revised on 04/23/24, indicated he had an activities of daily living (ADL) self-care performance deficit related to a history of traumatic subdural hemorrhage with loss of consciousness from a fall downstairs and cognitive impairment. The interventions included for staff to encourage him to use his bell | F 558 | F558<br>1. Resident #5 and #7 call lights were confirmed to be in place on May 9, 2024 by the Administrator.<br><br>2. An audit was completed on May 9, 2024, by the Administrator or designee of the current residents to ensure call light was in reach and all call lights were in reach.<br><br>3. All associates will receive education from Administrator or designee that all residents call lights must be in place by May 31, 2024. Agency Associates will be trained prior to working the floor.<br><br>4. The Administrator or designee will complete audits of at least 8 residents weekly for 4 weeks and monthly for 2 months to ensure resident call light is within reach.<br><br>5. The Administrator or designee will report findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting for at least 3 months for review to ensure compliance.<br><br>Date of Compliance: June 11, 2024 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345520 | A. BUILDING _____ B. WING _____ | C 05/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB | 1028 BLAIR STREET THOMASVILLE, NC 27360 |

| (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 558 | Continued From page 8 | F 558 | | |

to call for assistance. Another focus read Resident #5 had an actual fall and was at risk for additional falls related to confusion and history of a fall with serious injury prior to admit to facility. The interventions included for staff to be sure his call light was within reach and encourage the resident to use it for assistance as needed. The resident needs a prompt response to all requests for assistance.

An observation was conducted on 05/08/24 at 9:55 AM of Resident #7 lying in bed resting with eyes closed. His call bell was tied onto the bottom of the grab rail on the left side of bed out of the residents ' reach. Resident #7 declined to be interviewed.

An interview was conducted with Nursing Assistant (NA) #1 on 05/09/24 at 11:40 AM. She verified she was the direct care NA for Resident #7 ' s room. She indicated she checked call bell placement prior to leaving the rooms. NA #1 verified Resident #7 does utilize his call bell for assistance at times. She indicated she did not check his call bell placement upon leaving his room today.

An interview was conducted on 05/09/24 at 10:52 AM with Nurse #1. She verified that Resident #7 ' s call bell was tied on the bottom of the grab rail where the resident could not reach it. She indicated he gets up unassisted and ambulated but had used the call bell in the past. She stated Resident #7 does require assistance with his activities of daily living (ADLs).

An interview was conducted on 05/09/24 at 1:10 PM with the Director of Nursing (DON). She stated the call bell device should always be within

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345520 | A. BUILDING _____ B. WING _____ | C 05/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB | 1028 BLAIR STREET THOMASVILLE, NC 27360 |

| (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 558 | Continued From page 9 | F 558 | | |

the resident ' s reach.

2. Resident #5 was admitted to the facility on 11/07/23 with diagnosis that included chronic osteomyelitis (inflammation of bone or bone marrow) of right thigh and difficulty walking.

The quarterly Minimum Data Set (MDS) assessment dated 03/15/24 indicated Resident #5 ' s cognition was intact. She had no behavior and no rejection of care. She required moderate assistance of 1 for toileting hygiene and minimal assistance with shower/baths. She was always continent of bowel and bladder. She had no functional limitation with range of motion of her extremities.

Resident #5's active care plan, last revised on 04/23/24, indicated she had an activities of daily living (ADL) self-care performance deficit related to pain in her right hip. The interventions included for staff to encourage the resident to use bell to call for assistance. Another focus read Resident #5 had an actual fall and was at risk for additional falls related to generalized muscle weakness and poor safety awareness. The interventions included for staff to be sure her call light was within reach and encourage the resident to use it.

An observation and interview were conducted on 05/08/24 at 10:15 AM. Resident #5 ' s call bell was located on the floor behind a box at the head of bed. Resident indicated she could not locate her call bell. She stated she did not know how the call bell got up against the wall under the box, it had been there a while. She also stated she would use her call bell if she needed to.

An interview was conducted on 05/08/24 at 10:18

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345520 | A. BUILDING _____ B. WING _____ | C 05/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB | 1028 BLAIR STREET THOMASVILLE, NC 27360 |

| (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 558 | Continued From page 10<br>AM with NA #3. She verified she was the direct care NA for Resident #5 and that her call bell was on floor behind a box at head of bed. She stated Resident #5 does not use her call bell, but she does require assistance with her activities of daily<br><br>living (ADLs). She stated she checks for call bell placement prior to leaving a room but she did not recall if she checked Resident #5 ' s call bell the last time she was in the room.<br><br>An observation was conducted on 05/09/24 at 10:10 AM. Resident #5 ' s call bell was located on the floor behind a box at head of bed. Resident stated the call bell was under a box and she could not currently reach it. She stated she did not know how the call bell got under the box; it had been there a while. She indicated she did not use the call bell often, but she would if it was within reach, and she needed to do so.<br><br>An interview was conducted on 05/09/24 at 10:52 AM with Nurse #1. She verified that the Resident #5 ' s call bell was on floor behind a box at head of bed. She stated Resident #5 did not normally use her call bell, but she does require assistance with her activities of daily living (ADLs).<br><br>An interview was conducted on 05/09/24 at 1:10 PM with the Director of Nursing (DON). She stated the call bell device should always be within the resident ' s reach. | F 558 | | |
| F 565 SS=E | Resident/Family Group and Response<br>CFR(s): 483.10(f)(5)(i)-(iv)(6)(7)<br><br>§483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility.<br>(i) The facility must provide a resident or family | F 565 | | 6/11/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345520 | A. BUILDING _____ B. WING _____ | C 05/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB | 1028 BLAIR STREET THOMASVILLE, NC 27360 |

| (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 565 | Continued From page 11<br>group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.<br>(ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.<br>(iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.<br>(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.<br>(A) The facility must be able to demonstrate their response and rationale for such response.<br>(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.<br><br>§483.10(f)(6) The resident has a right to participate in family groups.<br><br>§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, resident, and staff interviews, the facility failed to communicate the facility's efforts to address group concerns verbalized during Resident Council meetings and to resolve repeat concerns for 8 of 9 consecutive months (September 2023, October 2023, | F 565 | F565<br>1. Resident Council Meeting concerns resolutions were communicated to Resident Council on May 28, 2024 for the Months of September 2023, October 2023, November 2023, December 2023, | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345520 | A. BUILDING _____ B. WING _____ | C 05/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB | 1028 BLAIR STREET THOMASVILLE, NC 27360 |

| (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 565 | Continued From page 12<br>November 2023, December 2023, January 2024, February 2024, March 2024, and April 2024).<br><br>Findings included:<br><br>a. Resident Council minutes dated 09/07/23 indicated residents had voiced concerns related to Nursing Assistants (NAs) not providing activity of daily living (ADL) care (not following the bath schedule) and food being cold when served. There was no evidence of the facility ' s response to the concerns voiced during the previous meeting had been reviewed or discussed.<br><br>b. Resident Council minutes dated 10/03/23 indicated residents had voiced concerns related to Nursing Assistants (NAs) not providing activity of daily living (ADL) care (NAs leaving residents soiled for extended period) and food being cold when served. There was no evidence of the facility ' s response to the concerns voiced during the previous meeting had been reviewed or discussed.<br><br>c. Resident Council minutes dated 11/02/23 indicated residents had voiced concerns related to Nursing Assistants (NAs) not providing activity of daily living (ADL) care and food not being on time. There was no evidence of the facility ' s response to the concerns voiced during the previous meeting had been reviewed or discussed.<br><br>d. Resident Council minutes dated 12/07/23 indicated residents had voiced concerns related to Nursing Assistants (NAs) call light response time and food being cold when served. There was no evidence of the facility ' s response to the concerns voiced during the previous meeting had | F 565 | January 2024, February 2024, March 2024, and April 2024 by the Administrator or designee.<br><br>2. An audit was completed on May 9, 2024, by the Administrator or designee of all resident concerns from resident council meeting minutes for the following months September 2023, October 2023, November 2023, December 2023, January 2024, February 2024, March 2024, and April 2024 to obtain all concerns communicated in the meetings in an ad hoc Resident Council meeting conducted on May 28, 2024.<br><br>3. Education was provided to the Activities department on procedure communicating concerns from resident council and that all resolutions to concerns must be communicated back to resident council on May 10, 2024, by Administrator.<br><br>4. The Administrator or designee will complete audits of resident council meeting minutes to ensure all concerns were addressed and communicated. Magnolia Gardens will conduct weekly resident council meetings for 4 weeks starting the week of May 27, 2024 and the return to monthly resident council meeting.<br><br>5. The Administrator or designee will report findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting for at least 3 months for review to ensure | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345520 | A. BUILDING _____ B. WING _____ | C 05/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB | 1028 BLAIR STREET THOMASVILLE, NC 27360 |

| (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 565 | Continued From page 13<br>been reviewed or discussed.<br><br>e. Resident Council minutes dated 01/04/24 indicated residents had voiced concerns related to Nursing Assistants (NAs) not providing activity of daily living (ADL) care (not following the bath schedule) and food being cold when served. There was no evidence of the facility ' s response to the concerns voiced during the previous meeting had been reviewed or discussed.<br><br>d. Resident Council minutes dated 02/08/24 indicated residents had voiced concerns related to Nursing Assistants (NAs) call light response time slow and food not coming out on time. There was no evidence of the facility ' s response to the concerns voiced during the previous meeting had been reviewed or discussed.<br><br>e. Resident Council minutes dated 03/07/24 indicated residents had voiced concerns related to Nursing Assistants (NAs) call light response time slow and food being cold when served. There was no evidence of the facility ' s response to the concerns voiced during the previous meeting had been reviewed or discussed.<br><br>f. Resident Council minutes dated 04/24/24 indicated residents had voiced concerns related to Nursing Assistants (NAs) call light response time slow. There was no evidence of the facility ' s response to the concerns voiced during the previous meeting had been reviewed or discussed.<br><br>The facility ' s concern log revealed no documented concerns from the Resident Council from September 2023 through April 2024. | F 565 | compliance.<br><br>Date of Compliance: June 11, 2024 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345520 | A. BUILDING _____ B. WING _____ | C 05/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB | 1028 BLAIR STREET THOMASVILLE, NC 27360 |

| (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 565 | Continued From page 14<br>An interview was conducted on 05/08/24 at 12:45 PM with the Administrator. He indicated the concerns that were reported in resident council meetings would be written up by the Activity Director and given to the department head responsible so an investigation could be conducted. He was unaware the resident concerns were not addressed from September 2023 through April 2024.<br><br>An interview was conducted on 05/09/24 at 12:45 PM with Resident # 11, Resident Council President, and Resident #12, Resident Council Co-President, was conducted. Resident # 11 stated they did not receive feedback from staff when group concerns were voiced. Resident # 11 further voiced they have complained multiple times regarding receiving activity of daily living (ADL) care and call bell response time being slow, however, nothing gets resolved. He then stated the Nursing Assistants (NAs) stand around at the nurses ' station and gossip and talk about personal things until 7:45-8:00 AM when they should be starting work at 7:00 AM. He indicated he did not know if the old Activity Director was giving the concerns to the Director of Nursing (DON) or the Administrator. Resident # 12 agreed with Resident # 11 ' s comments.<br><br>Multiple phone calls to contact the Previous Activities Director were unsuccessful. The Previous Activities Director was employed from 08/02/23 through 04/09/24. | F 565 | | |
| F 689 SS=D | 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 - | F 689 | | 6/11/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345520 | A. BUILDING _____ B. WING _____ | C 05/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB | 1028 BLAIR STREET THOMASVILLE, NC 27360 |

| (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 689 | Continued From page 15<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 interviews, the facility's administration failed to investigate and complete a root cause analysis for a fall for 1 of 4 residents reviewed for accidents. (Resident #8). The deficient practice led to the inability to implement effective interventions to prevent a reoccurrence.<br><br>The findings included:<br><br>Resident # 8 was admitted to the facility on 01/26/24 with diagnosis that included disorder of the brain, repeated falls, and paranoid schizophrenia.<br><br>Resident #8 ' s significant change Minimum Dat Set (MDS) assessment dated 02/02/24 indicated her cognition was severely impaired. She had one fall with major injury since admission or reentry. She required moderate assistance for bed mobility and minimal assistance for transfers.<br><br>Resident #8 ' s care plan, last revised 04/23/24, indicated she was at risk for falls related to confusion, deconditioning, impaired balance during transitions; poor safety awareness, and she does not call for assistance. The interventions included for staff to anticipate and meet the resident's needs, be sure call light is within reach and encourage the resident to use it for assistance as needed. The resident needed a | F 689 | F689<br>1. A complete investigation to include a root cause analysis was conducted on May 10, 2024, by Director of Nursing.<br><br>2. An audit was completed on May 9, 2024, by the DON or designee of all falls that happened in last 60 days to ensure proper investigation and root cause analysis was conducted with all containing an investigation that included a root cause analysis.<br><br>3. Education was provided to all Licensed Nurses on how to complete a fall investigation that includes a root cause analysis by May 31, 2024 by DON or designee.<br><br>4. The Director of Nursing or designee will audit all falls to ensure all falls have an investigation and root cause analysis for 4 weeks staring May 27, 2024 and then monthly for 2 months.<br><br>5. The Director of Nursing or designee will report findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting for at least 3 months for review to ensure compliance. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345520 | A. BUILDING _____ B. WING _____ | C 05/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB | 1028 BLAIR STREET THOMASVILLE, NC 27360 |

| (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 689 | Continued From page 16<br>prompt response to all requests for assistance and to ensure that the resident is wearing appropriate footwear when ambulating.<br><br>An incident report, dated 04/25/24, revealed a fall with no injury. Resident #8 was noted to be sitting upright in hall. Resident #8 stated she was trying to go backwards in her wheelchair and fell out of it. The report also revealed she was alert and oriented to person, place, time, and situation with predisposing factor being gait imbalance.<br><br>The nursing notes reviewed from 04/25/24 through 05/08/24 there was no at risk meeting related to fall that occurred on 04/25/24.<br><br>An interview was conducted on 05/08/24 at 1:32 PM with the Director of Nursing (DON). She stated falls are discussed every morning in the meeting and then documented in the nurses ' notes. She indicated she did not have an actual at risk meeting. She also indicated she was responsible for completing a root cause analysis for falls. She further stated if there were no notes documented in the nursing notes regarding a fall then there were not any. She was unable to provide documentation of root cause analysis for Resident #8 ' s fall on 04/25/24. | F 689 | Date of Compliance: June 11, 2024 | |
| F 867 SS=E | QAPI/QAA Improvement Activities<br>CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)<br><br>§483.75(c) Program feedback, data systems and monitoring.<br>A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the | F 867 | | 6/11/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345520 | A. BUILDING _____ B. WING _____ | C 05/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB | 1028 BLAIR STREET THOMASVILLE, NC 27360 |

| (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 867 | Continued From page 17 | F 867 | | |

following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345520 | A. BUILDING _____ B. WING _____ | C 05/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB | 1028 BLAIR STREET THOMASVILLE, NC 27360 |

| (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 867 | Continued From page 18 | F 867 | | |

improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345520 | A. BUILDING _____ B. WING _____ | C 05/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB | 1028 BLAIR STREET THOMASVILLE, NC 27360 |

| (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 867 | Continued From page 19<br>available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.<br><br>§483.75(g) Quality assessment and assurance.<br><br>§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:<br><br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br>(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, and staff interview the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification and complaint investigation surveys completed on 09/01/22 and 07/20/23. This was for 2 deficiencies that were cited in the areas of Resident Rights/Exercise of Rights and Reasonable Accommodation of Needs/Preferences. Resident Rights/Exercise of Rights was cited on the recertification and complaint survey on 09/01/22 and recited on the | F 867 | F867<br><br>1. The facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the 9/1/2022 Recertification and complaint Survey the facility was cited for Resident Rights (F550) and during the 7/20/2023 Recertification and Complaint Investigation Survey the facility was cited for Reasonable Accommodations (F558). | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345520 | A. BUILDING _____ B. WING _____ | C 05/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB | 1028 BLAIR STREET THOMASVILLE, NC 27360 |

| (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 867 | Continued From page 20<br>current complaint survey of 05/09/24. Reasonable Accommodation of Needs/Preferences was cited on 07/20/23 and recited on the current complaint survey of 05/09/24. The continued failure of the facility during three federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program (QA).<br><br>The findings included:<br><br>This citation is cross referred to:<br><br>1. F550-Based on record review, observations, resident, and staff interviews the facility failed to provide care in a manner to maintain the resident's dignity by not answering call bells for residents that need extensive assistance with activities of daily living (ADLs). This was evident for 3 of 6 residents (Resident #10, Resident #3, and Resident #4) reviewed for dignity.<br><br>During the facility's recertification and complaint survey of 9/1/22, the facility failed to promote dignity by not providing privacy cover over a urinary catheter drainage bag for one resident. This occurred for 1 of 6 residents reviewed for dignity.<br><br>2. F558-Based on observation, record review, resident interviews, and staff interviews, the facility failed to place a resident's call light (Resident #5 and #7) within reach to allow for the residents to request staff assistance this was for 2 of 3 residents reviewed for accommodation of needs.<br><br>During the facility's recertification and complaint survey of 07/20/23, the facility failed to provide a | F 867 | These deficiencies were recited again on the current Complaint Investigation Survey of 5/8/2024. The continued failure of the facility to ensure compliance in the two previously deficient areas showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance program.<br><br>2. The current residents are at risk related to this deficient practice.<br><br>3. The Administrator initiated an in-service to all administrative staff on 3/29/24 regarding Quality Assurance Performance Improvement (QAPI) process including identifying and prioritizing quality deficiencies, systemically analyzing causes of quality deficiencies, developing, and implementing corrective action or performance improvement activities. This in-service included accuracy of audits, extending audits when appropriate, and reviewing corrective action/performance improvement activities to evaluate the effectiveness of each plan and revise, as necessary. All newly hired administrative staff will receive the appropriate education during orientation. No Administrative staff worked util they received appropriate education.<br><br>4. The QAPI committee will review the compliance audits to evaluate continued compliance. The committee will make recommendations if any noncompliance is identified and reevaluate the plan of | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345520 | A. BUILDING _____ B. WING _____ | C 05/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB | 1028 BLAIR STREET THOMASVILLE, NC 27360 |

| (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 867 | Continued From page 21<br>dependent resident with a wheelchair to accommodate her size and inability to sit up. The resident was unable to get out of bed unless the staff borrowed a wheelchair from another resident with the same accommodation needs for 1 of 2 residents reviewed for accommodation of needs.<br><br>A phone interview was conducted on 05/21/24 at 3:23 PM with the Administrator. He stated the citations repeated, but the same issues did not repeat. He indicated he felt the current interventions in place are effective for the issues being cited in previous surveys. | F 867 | correction for possible revisions. This process will continue until the facility has achieved three months of consistent compliance. The Administrator will be responsible for the plan of correction.<br><br>Date of Compliance: June 11, 2024 | |