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 07/11/2024

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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 7/8/2024 through 7/11/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #PBWN11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 7/8/24 through 7/11/24. Event ID# PBWN11. The following intakes were investigated NC00219295, NC00219221, NC00218634, NC00213783, NC00217582, NC00214127, NC00209528, NC00217272, NC00216686, NC00211700, NC00208085, NC00207550, NC00207332. 3 of the 39 complaint allegations resulted in deficiency.	F 000		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;	F 690		8/2/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 07/29/2024

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 690	Continued From page 1 (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and interviews of staff, the resident, and the nurse practitioner, the facility failed to correctly transcribe the resident's (Resident #57) nephrology order for sterile saline flush 15 to 30 milliliters of the suprapubic urinary catheter every 12 hours. The resident's order was put in as a "one-time order" and only one sterile saline flush was completed. This deficient practice affected 1 of 3 residents reviewed for urinary catheter. Findings included: Resident #57 was admitted to the facility on 3/12/21 with the diagnosis of neurogenic bladder. Resident #57's quarterly Minimum Data Set dated 6/26/24 documented the resident's cognition was intact. The resident had a suprapubic urinary catheter and the diagnosis of neurogenic bladder.	F 690	1. Resident #57 nephrology order for sterile saline flush 15 to 30 milliliters of the suprapubic urinary catheter every 12 hours was corrected on July 8, 2024. 2. An audit was completed on July 8, 2024, by the ADON of the current resident with orders to flush urinary catheters to ensure that the order was transcribed correctly. 3. Licensed nurses were educated on correctly transcribing resident orders for urinary catheter flushes by the assistant Director of nursing. Any nurse that has not received the education by August 2, 2024 will be unable to work until the education is completed. Nearly hired nurses will receive the education from the	

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F 690 Continued From page 2

The care plan dated 5/23/24 for Resident #57 had a planned area for suprapubic urinary catheter. The interventions were monitor/document for signs and symptoms of urinary tract infection and report to the physician and to position the catheter bag and tubing below the level of the bladder.

Resident #57's nephrology consultation visit note dated 7/5/24 documented for staff to flush her suprapubic urinary catheter with 15 to 30 milliliters of sterile saline every 12 hours. The resident was to return for follow up after 7/28/24.

Resident #57 had an order entered on 7/5/24 by Nurse #1 for a "one time order" to flush the suprapubic urinary catheter every 12 hours with 15 to 30 milliliters of sterile water.

A review of Resident #57's Medication Administration Record (MAR) documented on 7/5/24 day shift one flush of the suprapubic urinary catheter. The remaining dates for the month of July to the 30th had no signatures. There was an "x" in the place to sign.

On 7/9/24 at 10:30 am an interview was conducted with Resident #57. Resident #57 stated she saw the urologist and he ordered her suprapubic urinary catheter to be flushed twice a day. She further stated that the staff had "not flushed her catheter twice a day." When she asked the staff about the catheter flush the nurse still had not flushed the catheter. Resident #57 commented that she had no signs or symptoms of urinary tract infection (UTI) at this time.

On 7/9/24 at 1:30 pm an interview was conducted

F 690

assistant director of nursing during orientation.

4. The DON or designee will complete audits of residents with an order for flush of urinary catheter for 4 weeks and monthly for 2 months to ensure resident order was correctly transcribed into the Electronic Medical Record.

5. The DON 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.

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F 690	Continued From page 3	F 690		

with the Assistant Director of Nursing (ADON). The ADON stated that Resident #57's suprapubic urinary catheter flush order was incorrectly placed into the system as a one-time order. Nurse #1 incorrectly entered the order for "one-time order to flush the catheter every 12 hours" on 7/5/24. At 2:30 pm the ADON checked with Nurse #1 and the resident's MAR, the resident's catheter was only flushed once by Nurse #1 who entered the order on 7/5/24 day shift. There were no continued flushes after this date/shift.

On 7/9/24 at 3:35 pm an interview was conducted with the Corporate Nurse Consultant. During the interview Resident #57's medical record was displayed to read. The Corporate Nurse stated the resident's order to flush the suprapubic urinary catheter every 12 hours was placed in the order system for "one-time only" in error. The order reflected as completed and there would not have been an order for the nurses to follow for every 12 hours ongoing. The Corporate Nurse stated she would correct this, and the resident would have her catheter flushed now.

Resident #57 had an order entered on 7/9/24 second shift by the Assistant Director of Nursing to flush the suprapubic urinary catheter every 12 hours with sterile water (15-30 ml) every day and evening shift for UTI for 28 Days.

On 7/10/24 at 9:00 am an interview was conducted with Nurse #1. Nurse #1 stated she was regularly assigned to Resident #57 on day shift. Nurse #1 stated she entered Resident #57's order in the electronic medical record for suprapubic urinary catheter flush on 7/5/24. Nurse #1 was not sure if the order was entered as a one-time order. Nurse #1 stated there was

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F 690	Continued From page 4	F 690		

not currently a place/order in the MAR to document the catheter flush. The order was showing as completed (7/5/24). Nurse #1 stated she would document any catheter flushes completed in the nurses' notes because it was no longer in the resident's orders. Nurse #1 stated she had not documented in the nurses notes a catheter flush. Nurse #1 stated if she needed to flush the catheter, she would use a prior order that was not discontinued.

A review of Resident #57's orders, including discontinued orders, had not revealed an order to flush the catheter in the past six months (1/8/24).

A review of Resident #57's nurses' notes had not revealed any documentation of the suprapubic urinary catheter flush for the past 90 days (4/8/24).

On 7/10/24 at 9:11 am an interview was conducted with the Nurse Practitioner (NP). The NP stated she was very familiar with Resident #57. The resident saw the urologist on 7/5/24 with sterile saline suprapubic urinary catheter flush every 12-hours order. The NP stated she asked staff and reviewed the resident's chart and there was no standing order for urinary catheter flush or prior order in place to flush the catheter. The NP was not aware the resident had not received the ordered urinary catheter flushes after 7/5/24. The resident was oriented and could ask when the new order from urology was not completed (catheter flush) because she was aware of the order. The NP was made aware that the order was corrected on 7/9/24 in the evening for the catheter flush. At 11:30 am the NP assessed the resident and stated the resident had no signs or symptoms of a UTI from the

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F 690	Continued From page 5 missed urinary catheter flushes from 7/5/24 to 7/9/24. On 7/11/24 at 9:30 am an interview was conducted with Resident #57. She stated her urinary catheter was now being flushed twice a day.	F 690		