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 09/25/2024

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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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 09/22/2024 through 09/25/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #L7UR11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 09/22/2024 through 09/25/2024. Event ID# L7UR11. The following intakes were investigated NC00215531, NC00221013, NC00221005 and NC00221198. 3 of the 13 complaint allegations resulted in deficiency.	F 000		
F 575 SS=C	Required Postings CFR(s): 483.10(g)(5)(i)(ii) §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation,	F 575		10/23/24

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

Electronically Signed | 10/19/2024

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F 575	Continued From page 1 misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to post a list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, the home and community based service programs, and the Medicaid Fraud Control Unit. This observation occurred for 3 of the 4 days during the onsite recertification survey. The findings included: Observations of the entire facility were completed on 9/22/24 at 2:37 pm and on 9/23/24 at 10:35 am. The observations revealed no signage or postings which included name and contact information for the State Survey Agency, complaint intake, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, or the Medicaid Fraud Control Unit. On 9/24/25 at 5:19 pm, a tour of the facility was completed. The main hallway (upper level) which included the dining room, did not have postings of	F 575	Magnolia Lane -F575 Required Postings " Magnolia Health 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 Health and Rehabilitation Center 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. Further, Magnolia Health and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. Problem Statement: " On 9/24/24, it was alleged that the facility failed to post a list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups. Address how the corrective action will be accomplished for those residents found to	

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F 575	Continued From page 2 all pertinent State agencies, advocacy groups, home and community based service programs, or the Medicaid Fraud Control Unit. Further observation of the facility revealed the main entrance, lobby and central hallway did not have postings of all pertinent State agencies, advocacy groups, home and community based service programs, or the Medicaid Fraud Control Unit. Continued observation of the facility revealed the Magnolia Hall (lower level) including the dining area and front lobby area did not have postings of all pertinent State agencies, advocacy groups, home and community based service programs, or the Medicaid Fraud Control Unit. An observation was completed with the Administrator on 9/24/24 at 5:29 pm of the entire facility. The observation revealed no postings of all pertinent State agencies, advocacy groups, home and community based service programs, or the Medicaid Fraud Control Unit. There was an enclosed signage station affixed to the wall adjacent from the nurse's station on the left side of the wall for postings in the lower level, but it was observed to be empty. An interview was completed with the Administrator on 9/24/24 at 6:03 pm. The Administrator stated the information should be posted with Regional, State, Local Ombudsman contact information and telephone number. The Administrator also stated the State Agency, advocacy groups, home and community based service programs, and the Medicaid Fraud Control Unit contact information and telephone numbers should be posted as well. The Administrator explained it had been posted previously but the building had undergone renovations, and the information must have been	F 575	have been affected by the deficient practice: " The facility licensed nursing home administrator is responsible for implementing the correction. " The facility licensed nursing home administrator was notified of the deficient practice on 9/24/24. The appropriate postings as defined in the state operations manual were posted on each unit on 9/24/24 in visual site for residents and staff by the licensed nursing home administrator. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: " A 100% audit of all units was conducted by the Social Worker on 9/24/24 to verify that all appropriate signage was placed on each unit as defined in the state operations manual. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: " The Social Worker will monitor that the appropriate signage is posted according to the state operations manual on each unit as part of the routine daily assigned rounds. Any concerns will be brought to the am Cardinal meeting and corrected immediately. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: " The Social Worker or the licensed nursing home administrator will audit the placement of the appropriate signage as outlined in the state operations manual on	

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F 575	Continued From page 3 taken down and not reposted.	F 575	each unit 3 times per week for 4 weeks. " All audits will be taken to Quality Assurance Performance Improvement monthly x1 month and discussed with the Interdisciplinary team (IDT) members. IDT team will determine at that time the need for continued monitoring.	
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations, resident council and staff	F 577	" Magnolia Lane Nursing and	10/23/24

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F 577	Continued From page 4 interviews, the facility failed to post signage about the availability of the most recent survey results for three (3) of four (4) days during the recertification survey. This had the potential to affect all residents residing in the building. The findings included: An observation was completed on 9/22/24 at 10:20 am of the front lobby which revealed no signage for the location of survey results. Additional observations were completed of the front lobby on 9/23/24 at 8:53 am and 9/24/24 at 9:15 am which revealed no signage for the location of the survey results. A Resident Council group meeting was conducted on 9/24/24 at 3:06 pm. During the meeting, all five of the residents in attendance indicated they did not know where the survey results were located. During a tour of the facility on 9/24/24 at 5:19 pm with the Administrator, signage for the location of survey results was not located in the building. Along the right wall of the front lobby was a brown side table. On the bottom shelf of the brown side table there was a grey binder with no labeling or signage along the spine. The bottom shelf of the brown side table was about 6 inches from the floor. In an interview on 9/25/24 9:51 am, the Receptionist stated she did not know of any signage for the location of the survey results. She stated she told people where the binder was if asked. The Receptionist then proceeded to the location of the survey results, which was in the far	F 577	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 Center 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. Further, 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 procedure and/or any other administrative or legal proceeding. Problem Statement: " It was alleged on 9/24/24 the facility failed to post signage about availability of the most recent survey results for 3 of four days Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: " The facility licensed administrator is responsible for implementing the plan of correction. " On 9/24/24 the survey binder with annual survey results included in accordance with the state operations manual was placed in reception lobby on foyer table with signage pointing to survey	

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F 577	Continued From page 5 corner of the front lobby on the bottom shelf of the brown side table. When the grey binder was removed from the bottom shelf of the brown side table, "Survey Reports" was written in white on the front cover of the binder. No labeling on the binder was visible from anywhere in the front lobby. During an interview on 9/25/24 at 11:17 am the Administrator stated there used to be signage posted for where to find survey results. She did not know why the sign was not up and further communicated the survey results signage was probably taken down during renovation. The Administrator voiced signage for the survey results should be visible and accessible for residents and visitors so the survey results were easy to locate.	F 577	binder location by the Director of Nursing. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: " On 10/21/2024 the Activity Director will hold an Ad Hoc resident council meeting informing all residents participating in resident council aware of the location of the facility survey result binder. " The Social Worker and the Activity Director will complete a 100% audit on 10/20/2024 of all alert and oriented residents with a BIMS greater than 13 to ensure they are aware of the location of the facility survey binder. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: " On 10/21/24 the facility Nurse Consultant will provide education on the appropriate placement of the facility survey results binder to the facility Licensed Nursing Home Administrator and the Director of Nursing Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: " The facility Licensed Nursing Home Administrator or the Director of Nursing will audit the placement of the facility survey results binder 3 times per week x 4 weeks	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii)	F 583		10/23/24

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F 583	Continued From page 6 §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain the privacy of a resident's record by leaving a medication cart laptop unattended with resident health	F 583	" Problem Statement: It was alleged that the Nurse #2 on Med-cart #1 failed to maintain the privacy of resident records by leaving a medication cart laptop	

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F 583	Continued From page 7 information exposed in an area accessible and visible to the public on 1 of 2 medication carts (medication cart #1). The findings include: During a continuous observation of Main Hall on 9/24/24 from 3:38 PM to 3:40 PM, medication cart #1 was observed unattended. The laptop screen was open and displayed resident information including, names, medications, and diagnosis. Several staff members and two visitors were observed passing by medication cart #1 while the laptop screen was open with the resident information exposed in an area accessible and visible to the public. On 9/24/24 at 3:40 PM Nurse #2 was observed returning to medication cart #1 from the nurse's desk that was approximately 20 feet away. An interview with Nurse #2 was completed on 9/24/24 at 3:40 PM. Nurse #2 reported she usually would have minimized the patient information screen to hide resident information when walking away from the medication cart. Nurse #2 went on to say she was just standing at the nurse's station and did not think about minimizing the screen, but normally she would. An interview was completed on 9/25/24 at 12:21 PM with the Director of Nursing (DON). During the interview the DON stated resident health information on the laptop screen should have been hidden by either minimizing the screen or locking/closing the laptop anytime the Nurse or Medication Aide walked away from the medication cart. The DON went on to say Nurse #2 should have made sure the laptop screen was	F 583	unattended with resident health information exposed on Main Hall. " The facility licensed nursing home administrator is responsible for implementing this plan of correction. " On 9/24/24, Nurse #2 was educated on Privacy and Confidentiality of records by the Director of Nursing to include reducing the laptop screen when not at the medication cart. " A 100% audit of all laptops on medication carts and visible was completed by the Administrator and Director of Nursing on 9/24/2024 with no additional findings. " Education was conducted by the Staff Development Coordinator with 100% of staff to include agency related to the protection of privacy and confidentiality fo records including reducing the laptop screen when not in use. The education began on 9/24/2024 and will be completed by 11/5/2024, any employees who have not worked or received the in-service will complete in-service prior to their next scheduled work shift. Any newly hired staff or agency staff will be educated by the Staff Development Coordinator during orientation and before their first shift starts. " The Director of Nursing or Assistant Director of Nursing will complete walking rounds 3 times weekly to observe for privacy and confidentiality of records including the visibility of resident information on laptops using the Privacy Audit tool beginning 10/1/2024 for 4 weeks to ensure compliance. If an issue is found during the audit immediate	

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F 583	Continued From page 8 hidden, and no personal health information was visible before she walked away from the medication cart.	F 583	re-education will be completed with that staff member by the Director of Nursing or Assistant Director of Nursing. The audit tool will be brought to the Quality Assurance Committee monthly for 3 months by the Director of Nursing to ensure compliance.	
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, staff, Pharmacy Consultant and Medical Director (MD) interviews, the facility failed to protect the resident's rights to be free from misappropriation of controlled substance for 1 of 1 resident reviewed for misappropriation of resident property (Resident #43). The findings included: Resident #43 was admitted to the facility on 10/3/23 with diagnoses that included chronic pain syndrome and phantom limb syndrome with pain. A review of the Physician orders for Resident #43 showed an order with a date of 10/3/23 for Oxycodone 10 milligrams (mg) (narcotic pain medication/controlled substance) to be given by	F 602	" Problem Statement: It was alleged that on 4/4/24 the facility reported an allegation of suspected drug diversion for 19 Oxycodone tablets. " The facility licensed nursing home administrator is responsible for implementing this plan of correction. " On 4/4/24, Resident #43 19 Oxycodone tablets were replaced at the facilities expense by Neil Medical Pharmacy. The Director of Nursing completed an audit of Resident #43 Medication Administration Records and Resident #43 received all medications as ordered including the Oxycodone. " A 100% audit of all residents receiving controlled substances was conducted on 10/11/24. All Medication Administration	10/23/24

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F 602	Continued From page 9 mouth three times a day. A review of the electronic medication administration record (eMAR) for 3/1/24 through 3/21/24 revealed Resident #43 had received the Oxycodone 10 mg three times a day for the entire month. A review of the packing slip from the Pharmacy dated 3/22/24 showed 60 tabs of Oxycodone 10 mg had been delivered for Resident #43 and signed by Nurse #7. A review of the controlled substance count record dated 3/22/24 showed there were 6 tablets of Oxycodone 10 mg remaining for Resident #43. Review of the shift change controlled substance count check sheets revealed missing information between 3/5/24 and 3/28/24. Review of the eMAR for 4/1/24 through 4/30/24 showed Resident #43 had received the Oxycodone 10 mg three times a day every day of the month. A review of the quarterly Minimum Data Set (MDS) assessment dated 4/19/24 revealed Resident #43 was cognitively intact and received routine pain medication during the 7-day lookback period. Review of the Initial allegation Report dated 4/4/24 read that there had been a suspected controlled substance diversion of Resident #43's narcotic pain medication following an attempt by the Assistant Director of Nursing (ADON) to refill narcotic medication from the pharmacy. There were 6 tablets of Oxycodone left on Resident	F 602	Records, narcotic count sheets and medication carts were completed for these residents included in this audit by the Director of Nursing and Assistant Director of Nursing with no additional negative findings. " Education was provided to the Administrator and Director of Nursing by the Operations consultant on 10/11/2024 related to the required reporting of missing narcotics to the appropriate state or federal agencies. On 10/11/2024 education began with all staff to include contract staff conducted by the Staff Development Coordinator related to Misappropriation of Resident Property. Any staff who have not worked or are newly hired staff or contract staff will be trained by the Staff Development Coordinator prior to working their first shift. " The Director of Nursing or Assistant Director of Nursing will complete an audit of the narcotic count sheets 5 times weekly for 4 weeks to ensure compliance. If an issue is found during the audit immediate investigation and reporting to appropriate state and federal agencies will be completed if any medication is found to be missing. The audit tool will be brought to the Quality Assurance Committee monthly for 3 months by the Director of Nursing to ensure compliance.	

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F 602	Continued From page 10	F 602		

#43's medication card. The ADON spoke with the pharmacist and was told there had been 60 tablets of Oxycodone delivered on 3/22/24. After reconciliation of the medication rooms and medication carts in the facility it was noted 19 tablets of Oxycodone was missing. The Administrator, Pharmacy, and Nurse Consultant were notified immediately. The Department of Public Safety was also notified. Nurse #7 was mentioned in the investigation and was suspended.

A review of a statement by Nurse #8 signed and dated 4/4/24 read in part: Nurse #8 remembered counting narcotics on 3/28/24 with Nurse #7 who was leaving from the night shift. Nurse #8 reported there were additional sheets that had to be removed on the Shift Change Controlled Substance count check form. Nurse #8 stated she had not seen the previous Shift Change Controlled Substance count check form. Nurse #8 voiced she would always check the count twice, counting sheets and medications. Nurse #8 also reported she had not had any issues with the count being incorrect.

A review of a statement by Nurse #7 signed and dated 4/5/24 read in part: Nurse #7 remembered signing the 3/22/24 delivery slip for Oxycodone, 60 tablets, 2 cards for Resident #43. Nurse #7 signed the sheets as she normally would do. Nurse #7 remembered starting the new card of Oxycodone on 3/28/24 and there were 56 tablets in total that morning. Nurse #7 reported she did not remember throwing away the empty card the night before but started a new card the morning of 3/28/24. Nurse #7 reported signing off with Nurse #8.

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Investigational Summary dated 4/7/24 was reviewed and it revealed the following information: On 4/4/24, the ADON was assisting the Nurse Practitioner (NP) in ensuring residents had scripts for controlled substances prior to the weekend. The ADON noted Resident #43 needed medication and spoke to the pharmacy who sated Resident #43 was not eligible for Oxycodone 10 mg to be refilled due to having received 60 tablets on 3/22/24. The DON was notified immediately and upon further investigation the DON noted Resident #43 had 6 tablets on the current medication card. Resident #43 was scheduled for 10 mg tablet three times a day and he had received his medications with no missed doses.

An interview was completed on 9/24/24 at 10:28 AM with Resident #43. During the interview Resident #43 reported he received routine pain medication, Oxycodone three times a day and recalled that he did not miss any of the doses of medication between the end of March 2024 and the beginning of April 2024 or have unrelieved pain.

During an interview conducted on 9/24/24 at 1:03 PM with the ADON, she recalled the missing Oxycodone for Resident #43 and what steps had been taken following the discovery of the missing medication. She said all medication sign-in sheets and medication count sheets for the Main Hall medication cart were audited. During the audit it was noted the medication sign-in sheets and medication count sheets were missing. The ADON notified the Administrator and local police once the missing medication was discovered and Nurse #7, the nurse that checked in the narcotic medication, had been suspended. The ADON further explained there had been back-up

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Oxycodone kept in the facility and that was why Resident #43 had not missed any doses of the medication. The ADON reported since the incident anytime narcotic medications were delivered two nurses had to sign for them and all information was verified including how many medications and medication cards were received.

An interview was completed on 9/24/24 at 3:23 PM with the Pharmacy Consultant. The Consultant was able to recall there had been an episode of drug diversion in the building in April 2024. She went on to say she had been notified of the incident and recalled anyone that had access to the medication cards and medications carts were drug tested and all the narcotic count sheets had been audited. The Consultant was unsure if missing 19 tablets of a narcotic medication, Oxycodone, was significant and did not see the need to contact any State of Federal agencies.

On 9/24/24 at 4:36 PM a telephone interview was completed with the Medical Director (MD). During the interview the MD reported he was aware of the missing narcotic medication for Resident #43. The MD further explained 19 tablets of missing narcotics would be a significant amount and the loss should have been reported to himself, the police, and any other State or Federal agencies that were necessary.

A telephone interview was completed on 9/24/24 at 5:33 pm with Nurse #7. During the interview Nurse #7 reported she was the Nurse that signed for the medications that had been delivered from the pharmacy on 3/22/24 for Resident #43. Nurse #7 reported she would administer medications to Resident #43 at times but could not recall when

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she last administered the medications. Nurse #7 went on to say she remembered checking and signing for 60 tablets of the narcotic medication, Oxycodone, for Resident #43 on the night of 3/22/24.

During an interview with the Administrator on 9/24/24 at 6:31 PM she revealed as soon as she had been notified of the missing narcotic medication, she, along with the ADON and the Director of Nursing (DON) went to both medication carts to make sure the missing medication had not been misplaced. She went on to say witness statements were gathered from the nurses that had administered or checked in the medication from pharmacy. The Administrator also said the local Police and members of the facility corporate team had been notified of the missing medication and Nurse #7 was suspended.

An additional interview was completed with the Administrator on 9/25/24 at 2:58 PM. The Administrator reported she had spoken with Resident #43 following the incident and notified him that the missing narcotic medication would be replaced at the cost of the facility. The Administrator explained after the incident the following entities were contacted; the pharmacy that delivered the medication, Adult Protective Services (APS), the local police department, the facility corporate office, Resident #43, and the facility Nurse Consultant. The Administrator voiced she felt like the missing 19 tablets of narcotic medication could be significant, but when she looked at the big picture, 19 tablets was a big number, but saying it was significant was subjective. The Administrator further explained that since the incident the facility corporate office

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F 602	Continued From page 14 made it clear on who and what entities needed to be contacted, but at the time they thought they were doing everything they should be doing.	F 602		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, and record review, the facility failed to provide assistance with oral care for 1 of 2 dependent residents (Resident #30) reviewed for activities of daily living (ADL). The findings included: Resident #30 was admitted to the facility on 2/14/2021 With a diagnoses of hemiplegia following cerebrovascular disease affecting left non-dominant side, muscle weakness, and chronic pain. A review of the annual Minimum Data Set (MDS) assessment dated 2/11/2024 revealed Resident #30 required set-up assistance with oral care, and he had obvious or likely cavities, broken teeth, and inflamed or bleeding gums with loose natural teeth. A review of the Care Area Assessment (CAA) dated 2/11/24 showed Resident #30 had natural teeth that were in poor repair. Within the CAA, reference to a physician note date 1/8/2024 revealed Resident #30 had a diagnosis of	F 677	" 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 Center 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. Further, 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 procedure and/or any other administrative or legal proceeding. Problem Statement: " It was alleged on 9/22 and 9/25/24 that the facility failed to provide assistance	10/23/24

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F 677	Continued From page 15 necrotizing periodontal disease, chronic periodontal disease and gingival disease. Review of the quarterly MDS assessment dated 7/5/24 revealed Resident #30 was cognitively intact and required set-up assistance with oral hygiene. No behavioral symptoms or rejection of care were noted. Review of care plan last updated on 7/23/24 revealed the following problem: Care deficit pertaining to the teeth or oral cavity characterized by altered oral mucous membrane, problems with natural teeth/gums or other oral dental health problems related to broken teeth, gums in poor condition. Goal in place for Resident #30 to be free of infection in the oral cavity through the next review. Interventions included provide/assist with oral hygiene as needed. There were no care plan in place for refusal of ADL care. A review of the Dental Hygienist note date 8/12/2024 showed oral care was provided to Resident #30 that included hand scaling, paste polish, and flossing. Per Hygienist, oral hygiene was poor, and most teeth were broken, and thick, heavy plaque was present on teeth. Instructions were given to resident and a recommendation for Staff to assist/brush Resident #30's teeth twice a day. An observation was made of Resident #30 on 9/22/24 at 11:06 AM that showed teeth were with thick yellowish substance on teeth and chipped and missing teeth. An additional observation was made on 9/25/24 at 10:03 AM of Resident #30. A toothbrush was observed in a wash basin on the bedside table	F 677	with activities of daily living related to oral care for resident #30. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: " The facility licensed administrator is responsible for implementing the plan of correction. " On 9/25/24 oral care was attempted to Resident #30 by assigned Nursing Assistant. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: " On 10/14/2024 the Director of Nursing, Assistant Director of Nursing and the Staff Development Coordinator completed a 100% audit of all residents oral care. Any concerns were addressed by the Director of Nursing immediately. Care plans were updated as appropriate and all supporting documentation has been reviewed. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: " On 10/11/24 the Director of Nursing and Staff Development Coordinator initiated education to the Nursing Assistants on documentation of refusal of care to include oral hygiene, how to address residents who refuse oral care and how to perform oral care. All inservicing will be completed by 10/16/2024. Any nursing assistant that has not completed the inservice education	

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that was across the resident. There was no toothpaste observed on the table or in the wash basin. The wash basin was dry.

A review of Resident #30's ADL documentation dated 9/10/24 through 9/25/2024 revealed there had not been any refusals of hygiene.

A review of Resident #30's progress notes dated 8/2/24 through 9/24/24 did not show any episodes of refusal of care, specifically oral care.

An interview was completed on 9/24/24 at 8:45 AM with Nursing Assistant (NA)#2. During the interview NA #2 reported Resident #30 would not let staff assist him with oral care, but he could benefit from additional assistance. NA # 2 went on to say Resident #30 will brush his teeth himself at times, but staff should be assisting to make sure he gets good oral care.

An interview and additional observation of Resident #30 was conducted on 9/24/24 at 11:41 AM. Resident #30's teeth remained coated in a thick yellowish substance. Resident #30 reported he needed assistance brushing his teeth and his teeth should at least be brushed at night. Resident #30 denied any pain or discomfort.

An interview with the Director of Nursing (DON) was completed on 9/24/24 at 1:09 PM. During the interview the DON reported recommendations from the Dentist were handed to the nurse and then given to the Physician when he was in the building. The Physician would sign off and return the recommendations to either the DON or the Assistant Director of Nursing (ADON) then uploaded into the computer system. The DON went on to say Resident #30 refused to have his

by 10/15/2024 will receive education prior to their next scheduled work date. Any newly hired nursing assistants hired after 10/16/2024 will receive education during orientation prior to start of their first shift.
Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:
" The Director of Nursing and the Assistant Director of Nursing will audit 5 residents weekly x 4 weeks to ensure oral hygiene has been performed and/or refusals have been documented.
" All audits will be taken to Quality Assurance Performance Improvement monthly x1 month and discussed with the Interdisciplinary team (IDT) members. IDT team will determine at that time the need for continued monitoring.

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teeth brushed but staff were supposed to provide set-up. The DON further explained staff needed to be at least applying toothpaste to Resident #30's toothbrush and assist with positioning and be sure to document any refusals of care. The DON further explained Resident #30's teeth were not being bushed as often as they needed to be.

On 9/25/24 at 10:05 AM an interview was completed with NA #4, who was familiar with Resident #30. During the interview NA #4 revealed mouth care was offered daily, prior to each meal. NA #4 went on to say Resident #30 preferred to do mouth care himself and did not like staff helping him, but there was nowhere to document any refusals. NA # 4 reported if a resident ever did refuse oral care, he would notify the nurse, and the nurse could document refusals in the notes.

During an interview with NA #6, who was familiar with Resident #30, on 9/25/24 at 10:09 AM it was revealed that anytime a resident refused care it should be documented in the NA charting. NA #6 further explained that if a resident had repeated refusals, the nurse would be notified. NA #6 also said she was not aware of any documentation showing Resident #30 refused oral care.

An interview was conducted with Nurse #5 on 9/25/24 at 10:13 AM. Nurse #5 reported if a NA came to her about repeated refusals she would document those refusals in the resident's notes. Nurse #5 went on to say Resident #30 was independent with oral care and did not need assistance, however he was not able to get to his toothbrush or toothpaste.

On 9/25/24 at 2:45 PM an interview was

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F 677	Continued From page 18 completed with the Administrator. The Administrator reported any resident that needed assistance with ADL care should receive that assistance and if they refused the care those refusals should be documented in the NA documentation and/or nurse's notes. The Administrator said Resident #30 was admitted with oral problems and did not allow staff to assist with oral care. The Administrator also reported oral care was kind of hit or miss and ADL care such as peri-care and bathing was looked at closer due to the ramifications of those care areas not being completed.	F 677		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.	F 693		10/23/24

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F 693	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to label tube feeding formula with the date and time the formula was hung and flow rate for 1 of 1 resident reviewed for tube feeding (Resident #26). The findings included: Resident #26 was admitted to the facility on 5/27/24 with diagnoses which included unspecified severe protein-calorie malnutrition and gastrostomy status (medical procedure where a tube is inserted through the abdominal wall and into the stomach). The quarterly Minimum Data Set (MDS) assessment dated 08/24/24 revealed Resident #26 was rarely/never understood and rarely/never understands. The nutritional approach while a resident was via feeding tube. Review of Resident #26's baseline care plan dated 05/29/24 revealed the resident was dependent on gastrostomy (G) tube for eating. The goal for Resident #26 was to maintain or achieve the highest practical level of functioning. Review of a physician order dated 08/05/24 revealed an order for Resident #26 to receive feeding formula infused at 55 milliliters (ml) per hour administered for 20 hours via pump infusion. Flush the enteral tube with 150 ml of water every 4 hours via pump. Tube feeding to be held for 4 hours daily at scheduled times (12 midnight). An observation conducted with Resident #26 on 09/23/24 at 10:03 AM revealed the resident's tube	F 693	" 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 Center 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. Further, 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 procedure and/or any other administrative or legal proceeding. Problem Statement: " It was alleged on 9/23 and 9/24/24 that Resident #26 had a tube feeding bag that was not labeled with the correct identifying information per order. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: " The facility licensed administrator is responsible for implementing the plan of correction. " On 9/24/24 Nurse #3 correctly labeled resident #26 feeding bag with the correct	

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F 693	Continued From page 20 feeding formula bag was not labeled with the resident's name, date and time it was hung and flow rate based on order. The pump was running at 55 ml per hour. Another observation conducted on 09/24/24 at 10:05 AM revealed Resident #26's tube feeding formula bag was labeled with the resident's name and date but no time and rate. An interview with Med Aide (MA) #1 on 09/24/24 at 10:10 AM revealed that she can only stop, hold, and resume a feeding pump. She verbalized that the nurses were the ones responsible for giving medications, flush, disconnect, and reconnect feeding tube to the pump. NA #4 said she had basic training in tube feeding during orientation. During an interview on 9/24/24 at 10:19 AM, Nurse #3 confirmed she was currently assigned to care for Resident #26. Nurse #3 stated the nurse working night shift was responsible for labeling the tube feeding as a new set of feeding formula and tubing were required. Nurse #3 stated the label should indicate the name of the resident, the rate, the time and date the tube feeding was placed and the name or the initials of the nurse. Nurse #3 revealed she received her basic training in tube feeding during orientation. An interview conducted with the Director of Nursing (DON) on 09/25/24 at 1:25 PM revealed the nurses in the facility received training in tube feeding during orientation with each resident receiving tube feeding. They did a demonstration and return demonstration before they were assigned to these residents. The DON verbalized that the facility conducted in-service training and	F 693	identifying information per order Address how the facility will identify other residents having the potential to be affected by the same deficient practice: " On 10/11/2024 the Director of Nursing, Assistant Director of Nursing and the Staff Development Coordinator completed a 100% audit of all residents on tube feedings to ensure that all identifying information is on the bag per the order. Any concerns were addressed by the Director of Nursing immediately. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: " On 10/11/24 the Director of Nursing and Staff Development Coordinator initiated education to the Nurses on appropriate way to label and tag tube feedings. All inservicing will be completed by 10/16/2024. Any nurses that have not completed the inservice education by 10/15/2024 will receive education prior to their next scheduled work date. Any newly hired nurses hired after 10/16/2024 will receive education during orientation prior to start of their first shift. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: " The Director of Nursing and the Assistant Director of Nursing will audit all residents with feeding tubes 3 times per week x 4 weeks to ensure all correct identifying information is labeled on each feeding bag. " All audits will be taken to Quality	

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F 693	Continued From page 21 education modules. The DON mentioned several nursing responsibilities such as checking tube placement and properly labeling the formula. The DON also said the nurses have worked there for a long time. She thought the nurses became complacent in labeling because of doing things repeatedly.	F 693	Assurance Performance Improvement monthly x1 month and discussed with the Interdisciplinary team (IDT) members. IDT team will determine at that time the need for continued monitoring.	
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff, facility Corporate Dietitian, Dialysis Center Registered Dietitian, and Medical Director interviews the facility failed to obtain a physician order for the resident to receive dialysis, monitoring of the dialysis access site, and fluid restrictions for 1 of 1 resident reviewed for dialysis (Resident #4). The findings included: a. Resident #4 was admitted to the facility on 8/1/2019 with diagnoses that included End Stage Renal Disease (ESRD) and Dependence Upon Renal Dialysis. A review of the most recent quarterly Minimum Data Set (MDS) dated 6/18/2024 revealed Resident #4 had moderate cognitive impairment with unclear speech and required substantial to	F 698	" Problem Statement: " On 9/25/2024 an order for dialysis was added to the residents□ physicians□ orders which included frequency and monitoring of access site as well as an order that reflects the resident□s fluid restrictions of 1200cc per day. The fluid restrictions were added to the resident□s dietary tray card by the Certified Dietary manager on 9/25/24. " The facility licensed nursing home administrator is responsible for implementing this plan of correction. " A 100% audit of all residents with dialysis services for appropriate physicians□ orders including the frequency and monitoring for the access site as well as an audit for any residents on fluid restrictions to ensure Dietary has that reflected on the tray card and the	10/23/24

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F 698	Continued From page 22 partial assistance with activities of daily living (ADLs). The MDS further showed Resident #4 received dialysis. During a review of Resident #4's care plan that was last updated on 7/9/2024 revealed Resident #4 was at risk for complications due to hemodialysis and attended dialysis 3 days a week, Monday, Wednesday and Friday. The goal read as follows; Will not experience complications from dialysis treatment without appropriate intervention. Interventions included Dialysis 3 days a week, communicate with dialysis treatment center as indicated for adjustments in resident's care and/or treatment plan, maintain dressing as ordered, monitor access site for bleeding and/or signs of infections, and Dressing to dialysis port to remain intact between dialysis days. A review of Resident #4's active orders revealed no order for dialysis that included frequency and no order for monitoring of access site. A review of Resident #4's electronic and hard copy medical record revealed the last communication sheet from the dialysis center was received July 10, 2024. Review of a progress note dated 9/23/24 showed a dialysis port to upper right side of chest with dressing that was clean, dry, and intact. A review of Resident #4's electronic medication administration record (eMAR) and electronic treatment administration record (eTAR) for the month of September revealed no place for documentation of access port care or place to document visits to the dialysis center.	F 698	order is in place was completed on 9/25/2024 by the Director of Nursing with no additional issues found. " Education began 9/27/24 with all registered and licensed nurses including contract staff by the staff development coordinator and Assistant Director of Nursing related to requiring a physician□s order for residents receiving dialysis to include the frequent and monitoring of the site access and any fluid restrictions. Any staff who have not worked or are newly hired staff or contract staff will be trained by the Staff Development Coordinator prior to working their first shift. " The Director of Nursing or Assistant Director of Nursing will complete an audit of residents receiving dialysis, physician orders and fluid restrictions, 3 times per week for 4 weeks to ensure compliance. If an issue is found, an order will be obtained, and the nursing staff will be retrained by the staff development coordinator. The audit tool will be brought to the Quality Assurance Committee monthly for 3 months by the Director of Nursing to ensure compliance.	

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An interview with Nurse #2 on 9/24/24 at 10:19 AM revealed she was unsure of a dialysis book; however, the Facility Receptionist was the one that kept track of all appointments and paperwork from appointments.

On 9/24/24 at 10:34 AM and interview with the Facility Receptionist revealed there was not a dialysis book, but the nurse would check the resident's vital signs and put it on a piece of paper that was sent with the residents to their appointments.

During an interview with Nurse #3 on 9/24/24 at 4:56 PM she reported if there were no dialysis orders or access site orders in place for a resident then the MD would need to be contacted to give orders, otherwise the care needed for a resident would not be clear.

On 9/25/24 an interview was completed with the Director of Nursing (DON). During the interview the DON reported the dialysis orders should have been restarted when Resident #4 returned to the facility following a hospital stay in March 2024 since he continued to need dialysis and attended dialysis 3 times a week, but the orders had not been restarted.

The Assistant Director of Nursing (ADON) was interviewed on 9/24/24 at 10:57 AM. During the interview the ADON reported there was a dialysis form that was sent with the resident but it was usually not sent back to the facility. The ADON went on to say even though the dialysis center did not send back the communication form the facility was able to call and request the form be sent back. The ADON went on to say once the

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communications forms were received, they would be uploaded into the electronic record. The ADON was unable to speak on why there were no dialysis communication forms in the system since July 10, 2024, for Resident #4. The ADON interview further revealed residents with any kind of access must be checked upon return from dialysis and there should be an order set in place for all dialysis residents. The ADON reported there should have been dialysis orders in place for Resident #4 as well as orders to check the access port.

An interview was completed on 9/24/24 at 4:24 PM with the Medical Director (MD). During the interview with the MD, it was revealed he did not believe an order for dialysis or access care was necessary if a diagnosis of ESRD was in place, but it would be "nice" to have orders for clarification.

An interview was completed with the Facility Administrator on 9/24/24 at 4:00 PM. During the interview the Administrator reported Resident #4 had been out at the hospital in March of 2024 and orders for dialysis and access site care had not been restarted upon his return. The Administrator reported the expectation was to have orders in place for dialysis residents.

b. During a review of Resident #4's care plan that was last updated on 7/9/2024 it showed Resident #4 had the potential for or actual fluid volume deficit due to fluid restrictions related to a renal diet, Dialysis 3x week, 1200 cubic centimeters (cc)/24-hour fluid restrictions. The goal in place for Resident #4 was to not demonstrate signs or symptoms of dehydration through the next review period. Interventions included restricted fluids to

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1200ml/day.

Review of Registered Dietitian (RD) note dated 7/15/2024 revealed Resident #4 was on a Renal diet, 1.2Liter fluid restrictions in place.

A review of Resident #4's orders last reviewed on 9/5/2024 revealed there was no order in place for 1200 cc/day fluid restrictions.

An observation on 9/22/2024 at 1:43 PM of Resident #4's meal ticket showed resident was on 1200cc /day fluid restrictions. There was one 8 ounce cup of fluid observed on the meal tray that equaled 236 cc's.

During an additional observation of Resident #4's meal ticket on 9/25/2024 at 8:40 AM it read, 1200 cc daily fluid restrictions (840cc dietary/360cc nursing). There was an 8 ounce cup of fluid (236 cc's) and a smaller, 4 ounce cup of fluid (199 cc's) that equaled 355 cc of fluid on the tray.

An interview was completed on 9/25/24 at 8:40 AM with Nursing Assistant (NA) #4. During the interview NA #4 reported he looked at the meal ticket before passing out any tray and he would ask the nurse about anything on the meal ticket that was different from what was on the tray, including fluids and fluid restrictions. NA #4 went on to say information could also be found under the resident care guide.

Observation of the resident care guide for Resident #4 on 9/25/24 at 8:44 AM with NA #4 revealed the resident was on fluid restrictions per dialysis of 1200cc day.

Interview with Nurse #5 on 9/25/24 at 8:49 AM

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F 698	Continued From page 26	F 698		

revealed she would check a resident's orders for any discrepancies that was discovered or brought to her attention including diet orders and if there was no order in place she would notify the Physician. Nurse #5 was not aware there was not an order for Resident #4 in place for fluid restrictions.

On 9/25/24 at 10:44 AM an interview was completed with the Facility Corporate Dietician. During the interview the Facility Corporate Dietician revealed any recommendations and changes in diet would usually be communicated with the Registered Dietician (RD) at the Dialysis facility. The Corporate Dietician went on to say if a resident was on fluid restrictions, then there should be an order in place stating what kind of fluid restrictions there should be. Corporate Dietician was not aware there was not an order in place for fluid restrictions for Resident #4, but there should have been one.

A telephone interview was completed on 9/25/24 at 11:35 AM with the Dialysis Center Registered Dietician (RD) that Resident #4 attended. During the interview the Dialysis Center RD reported she was aware Resident #4 was to be on 1200cc/day fluid restrictions. The RD also reported, several attempts had been made to contact the facility via telephone and fax regarding Resident #4's nutrition orders/fluid restrictions and no one had returned the communications following the departure of the former facility RD in March of 2024. The Dialysis Center RD went on to say if a resident was on fluid restrictions, then there should be an order in place stating how much fluid should be received during the day from dietary and nursing.

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F 698	Continued From page 27 During an interview with the Director of Nursing (DON) on 9/25/24 at 2:22 PM it was revealed that Resident #4's previous orders should have been updated following his return from the hospital. She went on to say, usually an audit was completed of all new admissions, readmission, and order changes during morning meeting. The DON also reported a communication form was sent with residents to dialysis so changes, including any nutritional changes, could be communicated. The DON was not able to speak on why there were no dialysis communication forms in the electronic health system for Resident #4 since July 10, 2024. The DON concluded the interview by saying there should have been an order for fluid restrictions. On 9/2/24 at 2:54 PM an interview was completed with the Administrator where she reported staff attempted to have Resident #4 take in fluids due to his poor intake at times. She went on to say anytime there was a change in diet it would go on a dietary slip and be communicated with the dietary department. The Administrator did say there should have been an order for fluid restrictions if that was what was communicated from the RD.	F 698		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and	F 732		10/23/24

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F 732	Continued From page 28 unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to post accurate Registered Nurse (RN) staffing information for 8 days of the 205 days reviewed for daily posted staffing (3/22/24, 4/10/24, 4/12/24, 4/22/24, 5/13/24,7/20/24, 8/17/24, 8/31/24). The findings included:	F 732	" 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	

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F 732	Continued From page 29 Review of the daily posted staffing from March 2024 through August 2024 revealed the daily posted staffing sheets were missing the Registered Nurse (RN) hours for the following days: a. The daily posted staffing sheet for 3/22/24 revealed the sections for RN hours were blank for all 3 shifts. b. The daily posted staffing sheet dated 4/10/24 revealed the sections for RN hours were blank for all 3 shifts. c. The daily posted staffing sheet dated 4/12/24 revealed the sections for RN and LPN hours were blank on 3rd shift. d. The daily posted staffing sheet dated 4/22/24 revealed the sections for RN hours were blank for all 3 shifts. e. The daily posted staffing sheet dated 5/13/24 revealed the sections for RN hours were blank for all 3 shifts. f. The daily posted staffing sheet dated 7/20/24 revealed the sections for RN hours were blank for all 3 shifts. g. The daily posted staffing sheet dated 8/17/24 revealed the sections for RN hours were blank for all 3 shifts. h. The daily posted staffing sheet dated 8/31/24 revealed the sections for RN hours were listed as 6 hours for 1st shift and blank for 2nd and 3rd shift.	F 732	written allegation of compliance. " Magnolia Lane Nursing and Rehabilitation Center 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. Further, 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 procedure and/or any other administrative or legal proceeding. Problem Statement: " It was alleged on 9/24/24 that the facility failed to post an updated daily nurse staffing information sheet as defined in the state operations manual. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: " The facility licensed administrator is responsible for implementing the plan of correction. " On 9/24/24 The Director of Nursing updated the daily nurse staffing information sheet, and it was posted by the facility Receptionist which included all data requirements as defined and required by the state operations manual. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: " On 10/11/2024 the Director of Nursing, Assistant Director of Nursing and Medical Records Coordinator completed a	

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F 732	Continued From page 30 During an interview on 9/24/24 at 11:49 am the Receptionist stated she was responsible for completing the daily staff posting with information received from Medical Records, who was also the Scheduler. The Receptionist stated on a weekend, there may have been a day without RN hours, but she was only responsible to enter the information that was received from Medical Records/Scheduler. She stated she had unexpected medical leave, and it was "hit or miss" who filled out the daily staff postings for part of that time. She further explained since her leave the back up and weekend receptionist have been trained to complete daily staff postings. During an interview on 9/24/24 at 12:06 pm the Medical Records/Scheduler stated she sent a copy of the schedule for the following day to the receptionist to be completed the next morning. She further explained that if there was not a RN on the schedule for the next day, she would notify the Assistant Director of Nursing (ADON) or Director of Nursing (DON), but she did not recall there being any days they did not have an RN in the building for at least 8 hours, and did not know why the daily staff posting was completed incorrectly. During an interview on 9/24/24 at 12:15 pm the DON stated the Medical Records/Scheduler sent the schedule to the receptionist to post. She further explained the Administrator would update the daily staff postings when there was not a receptionist. The DON stated she started as DON on 7/4/24 and did not remember there being a day that a RN had not worked at least 8 hours. The DON verified the daily staff postings from the 8 days listed above did not have any RN hours	F 732	100% audit of staffing sheets for the last 30 days to ensure all information was accurate. No additional concerns were identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: " On 10/11/24 the Director of Nursing provided education to the Receptionist, Medical Records Coordinator and Assistant Director of Nursing on the process of recording and posting daily staffing sheets as defined in the state operations manual. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: " The Director of Nursing and the facility licensed Nursing Home Administrator will audit the daily nurse staffing sheets 5 days per week x 4 weeks to ensure it is being updated and posted as defined in the state operations manual. Any concerns will be corrected immediately, and re-education provided by the Director of Nursing and the facility licensed Nursing Home Administrator. " All audits will be taken to Quality Assurance Performance Improvement monthly x1 month and discussed with the Interdisciplinary team (IDT) members. IDT team will determine at that time the need for continued monitoring.	

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F 732	Continued From page 31 recorded, but stated there was an RN working on the July 2024 and August 2024 dates listed. During an interview on 9/24/24 at 12:23 pm the ADON stated during the time the Receptionist was out on leave, several people had helped complete the daily staff postings. She further stated that she was not aware of any days that there was not an RN working for at least 8 hours per day. The ADON did verify that the 8 dates listed above did not have RN hours recorded on the daily staff postings, she explained she did not know why the daily staff postings were completed incorrectly. During an interview on 9/24/24 at 12:28 pm the Administrator stated the Receptionist completed the daily staff postings in the morning with the information received from the Medical Records/Scheduler. She further explained that if the receptionist was out, the RN in charge would complete it, or the Medical Records/Scheduler, DON or Administrator were able to complete it. The Administrator was not aware of any days the facility had not had a RN working for at least 8 hours. She verified the above 8 dates listed did not have RN hours recorded on the daily staff posting, but did provide payroll documents that showed RNs had worked at least 8 hours on the 8 listed dates. The Administrator said the daily staff postings should be accurate and match the actual RN hours worked. The Administrator was unsure how the daily staff postings for the 8 listed dates were completed with inaccurate RN hours.	F 732		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink	F 806		10/23/24

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F 806	Continued From page 32 Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to determine a resident's food preferences and failed to offer an alternative option. This occurred for 1 of 1 resident reviewed for choices (Resident #23). The findings included: Resident #23 was admitted to the facility on 8/1/24. The admission Minimum Data Set (MDS) dated 8/8/24 indicated Resident #23 was cognitively intact. A review of Resident #23's medical record revealed no food preference form. During an interview on 9/22/24 at 11:14 am Resident #23 stated he did not like chicken and did not wish to eat it. Resident #23 stated he did not ask staff for an alternate because he did not know he could. Resident #23 stated staff had not offered him an alternative when chicken was left on his plate. The resident stated he had not told a specific person that he did not eat chicken, but that he had complained about it to the staff that	F 806	" 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 Center 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. Further, 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 procedure and/or any other administrative or legal proceeding. Problem Statement: " It was alleged on 9/24/24 that the facility failed to provide food that accommodates resident preference for Resident #23.	

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	345219	A. BUILDING _____ B. WING _____	C 09/25/2024

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F 806	Continued From page 33 delivered and picked up his tray, when chicken came on his tray, which the resident stated was about 6 days a week. While in Resident #23's room on 9/22/24 at 1:23 pm, Nurse Aide (NA) #2 was observed to lift the lid on Resident #23's lunch plate which revealed two full pieces of chicken that remained untouched. Resident #23 told NA #2 he left the chicken on the plate and wrote on the tray ticket that he did not like chicken. NA #2 told Resident #23 she was sorry and knew the facility had chicken a lot then took the tray and left the room without offering Resident #23 an alternative food option. During an interview on 9/24/24 at 9:26 am NA #2 stated she would offer the resident a sandwich if the resident had untouched food on their tray and then contact the kitchen to let them know that a resident didn't like what was served. NA #2 confirmed that on 9/22/24 she had not offered an alternate to Resident #23 when there was untouched chicken on the plate and Resident #23 told her he did not like it and wrote that on the diet slip. NA #2 stated she didn't want to bother the resident since he had a visitor in the room. Review of Resident #23's breakfast meal ticket on 9/23/24 at 9:04 am revealed there were no dislikes listed. During an interview on 9/24/24 at 9:11 am Nurse #3 stated if a resident left food untouched on a plate, she would expect to be told by the NA that picked up the tray. Nurse #3 stated she would assess to see if that was a normal occurrence, if not, an assessment would be completed. Nurse #3 stated that if a resident told a NA they didn't	F 806	Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: " The facility licensed administrator is responsible for implementing the plan of correction. " On 9/24/24 Resident #23 was offered an alternative lunch which included his requested preferences, and he did accept. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: " On 10/18/24 the Dietary Manager and the Director of Nursing completed a 100% audit of resident food preferences and updated resident tray cards as appropriate. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: " On 10/11/24 the Administrator and the Director of Nursing conducted education with the Admissions Coordinator and the Dietary Manager on the process of obtaining resident preferences upon admission and as needed as well as offering an alternate meal if the resident refuses. All in servicing will be completed by 10/16/2024. All staff who assist in documenting resident meals preferences and meal distribution that have not completed the inservice education by 10/15/2024 will receive education prior to their next scheduled work date. Any newly hired staff responsible collecting resident meal preferences and distributing	

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F 806	Continued From page 34 like a certain food or wrote it on the diet slip, she would expect the NA to bring the diet slip to a nurse and the nurse would let dietary know or ask social work, admissions or activities to follow up about preferences. Nurse #3 stated the NAs that picked up meal trays should ask the resident if they wanted something else if they saw food left on a plate, and that leaving the room without offering another option was not the appropriate response because the resident should have been offered an alternate for the food left on the plate. During an interview on 9/24/24 at 9:17 am NA #1 stated if there was untouched food on a residents' tray, she would ask why they didn't eat and offer to get them something else and then let a nurse or dietary know. During an interview on 9/24/24 at 9:22 am Nurse #2 stated if a NA saw untouched food on a plate when it was picked up, she would expect them to tell the nurse, for the nurse to assess and find out what the resident would want to eat. Nurse #2 said it had not been reported to her that Resident #23 did not like chicken. During an interview on 9/24/24 at 9:41 am the Admissions Coordinator stated a food preferences form was completed by admissions, normally on the day a resident was admitted. The Admissions Coordinator explained they had an old form that was not very good, but a new form had been introduced on 07/25/24. The Admissions Coordinator expected the Dietary Manager to be notified by the NA or nurse if a resident had not eaten or if they didn't like a specific food. The Admission Coordinator stated that a preference sheet for Resident #23 had not been completed upon his admission.	F 806	meal trays after 10/16/2024 will receive education during orientation prior to start of their first shift. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: " The Director of Nursing and the will audit 5 residents weekly x 4 weeks to ensure preferences are being offered. " All audits will be taken to Quality Assurance Performance Improvement monthly x1 month and discussed with the Interdisciplinary team (IDT) members. IDT team will determine at that time the need for continued monitoring.	

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F 806	Continued From page 35	F 806		

During a follow-up interview with the Admission Coordinator on 9/25/24 at 8:41 am he stated that the old food preference form had not been completed on Resident #23 because they had stopped using the old form on 7/25/24 and he had until 10/01/24 to have it completed. He further stated he was working on getting all the forms completed for every resident in the building, including new residents and it took him approximately 40 minutes to complete each new food preference form on the tablet. The Admission Coordinator said food preference forms were typically done during admission or as soon as he could.

During an interview on 9/24/24 at 10:16 am the Nutrition Consultant #1 stated the Dietary Manager could review food preferences for residents and the staff should offer an alternate if a resident had untouched food on their plate and notify dietary staff to make sure the disliked item was on the diet card. He stated the Dietary Manager should speak to the resident about food preference if a dislike was reported and fill out a grievance if warranted. The Nutrition Consultant #1 stated he did not know of a policy for when food preferences should be completed.

During an interview on 9/24/24 at 10:20 am the Dietary Manager stated staff should offer an alternate and there should be notes for preferences on the diet card. The Dietary Manager stated nurses should tell dietary when a resident voiced a dislike. He was not aware of when food preferences were required to be completed.

During follow up interview on 09/25/24 at 8:51 am

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F 806	Continued From page 36 the Nutrition Consultant #1 stated the food preference form should be done as soon as possible, he was not aware who was responsible at this facility but had heard it was the Admission Coordinator. The Nutrition Consultant #1 stated that a resident admitted on 8/1/24 and not having food preferences completed until 9/24/24 was too long. Baseline preferences should be done within 24-72 hours of admission. During a follow up interview completed on 9/25/24 8:57 am the Dietary Manager stated he had not been notified before 9/24/24 that Resident #23 did not like chicken. He explained the food preference form was normally received within a couple days of a resident's admission. He further explained staff should offer an alternate meal if food was left untouched or a resident stated they didn't like an item on the plate. During an interview on 9/25/24 at 11:17 am the Administrator stated she would expect for dietary to know the food preferences of a resident within the first week after a resident's admission. The Administrator did not know why Resident #23 did not have a food preference form completed before 9/24/24, but was aware a new form had been introduced.	F 806		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812		10/23/24

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F 812	Continued From page 37 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to dry insulated bases, lids, pans and baking sheets before they were stacked for use, failed to store perishable food off the floor, failed to remove a dented canned good item stored for use, and failed to discard expired food and food items with signs of spoilage stored in 1 of 1 walk-in cooler and main dining room refrigerator. In addition, the facility failed to cover facial hair during food preparations. These practices had the potential to affect food served to residents. The findings included: a. An initial tour of the kitchen occurred on 09/22/24 at 10:34 AM with Cook #1 which revealed stacked wet items on tray line and storage rack: - 12 of 50 insulated bases - 10 of 10 dome lids - 2 rectangular pans - 3 deep rectangular pans - 2 small, deep rectangular pans - 2 long, rectangular pans	F 812	" 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 Center 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. Further, 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 procedure and/or any other administrative or legal proceeding. Problem Statement: " It was alleged on 9/22/24 that the	

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F 812	Continued From page 38 - 5 large baking sheets An interview with Cook #1 on 09/22/24 at 11:03 AM revealed all kitchen staff were responsible for making sure dishware was dry before stacking. During a combined interview on 09/24/24 at 12:26 PM with Nutrition Consultant #1 and Nutrition Consultant #2, they both expressed that all kitchen staff should be able to recognize when dishware was still wet before stacking and education to all kitchen staff was conducted. They also verbalized they ordered additional plastic racks to store clean equipment and dishware to allow air drying. b. During an initial tour of the kitchen on 09/22/24 at 10:46 AM, a box of potatoes was found on the floor with one potato on the floor inside the dry storage room. An interview with Cook #1 on 09/22/24 at 11:01 AM revealed she was in a hurry when preparing breakfast and placed the box of potatoes on the floor. Dietary staff #1 threw out the box of potatoes on 09/22/24 at 11:03 AM. An interview with the Dietary Manager (DM) on 09/24/24 at 12:26 PM revealed the food items should be placed on top of plastic milk carts found in the dry storage area. c. During an initial tour of the kitchen on 09/22/24 at 10:50 AM, one 6.63-pound (lb) can of beef stew was found on the shelf ready for use was observed with a dent around the rim/seal of the lid approximately of 1.5 inches in length and 0.5 inches deep.	F 812	facility failed to dry insulated bases, lids, pans and baking sheets before they were stacked for use, failed to store perishable food off the floor, failed to remove a dented canned good item, failed to discard expired food and food items with signs of spoilage stored in a walk-in cooler, and failed to cover facial hair during food preparations. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: " The facility licensed administrator is responsible for implementing the plan of correction. " On 9/22/24, the dietary aides and the dietary manager removed all perishable food that was identified from the floor and stored appropriately. Any dented can foods were removed, any the expired food and food items were removed and disposed of appropriately. " On 9/22/24, the Dietary Manager and the facility licensed Nursing Home Administrator gave all male staff working in dietary, beard guards and ensured they were wearing them. " On 9/22/24, the dietary aides and the dietary manager dried all insulated bases, lids, pans and baking sheets as appropriate prior to being stacked. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: " On 9/22/24, the dietary aides and the dietary manager conducted a 100% audit of all dry storage areas and coolers in the kitchen. All perishable food was removed	

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F 812	Continued From page 39 An interview with the DM on 09/24/24 at 12:28 PM revealed there was no dedicated area to place dented cans. He verbalized that the facility would assign an area where to place dented cans. d. The following food items were observed in the walk-in-cooler on 09/22/24 at 10:54 AM. A bag of shredded mixed cheese opened but not dated. A 5 pound sealed sour cream container with expiration date on 8/28/2024. A tub of pimiento spread unsealed, not dated and observed with black, green substance on lid edges and around the top of the container. The expiration date was unable to read. An Italian pasta salad container was opened and not dated with expiration on 08/23/2024. An interview with Cook #1 on 09/22/24 at 11:01 AM revealed that whoever opened, stocked, or used the food items last were responsible for labeling and dating food items. During an interview on 09/24/24 at 12:32 PM, the DM stated that all kitchen staff were responsible in labeling, dating and throwing away expired food items. The DM stated the kitchen staff would label food items when they came in from the supplier. e. Review of facility policy regarding outside foods indicated that food items must be approved by and cleared through the licensed supervisor, hall nurse, administrative nurse, or the Director of Nursing before being given to the resident. During an observation on 09/23/24 at 12:34 PM, a 30 fluid ounce container of mayonnaise with a best by date of 10/19/23 and 16 ounce thousand	F 812	from floor and stored appropriately. Any dented can foods were removed, any the expired food and food items were removed and disposed of appropriately. " On 9/22/24, the Dietary Manager and the facility licensed Nursing Home Administrator conducted a 100% audit of all staff members working in the dietary department to determine who would need to wear a beard net. All staff members were given beard guards working in dietary as appropriate. On 9/22/24, the dietary manager placed the beard guards with the hair net for easy access to dietary staff to access as they enter the kitchen area daily. " On 9/22/24, the dietary manager conducted a 100% audit of all insulated bases, lids, pans, and baking sheets. The dietary aides and the dietary manager dried all insulated bases, lids, pans and baking sheets as appropriate prior to being stacked. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: " On 10/11/24 the facility licensed Nursing Home Administrator and the Dietary Manager initiated education to all kitchen staff employees on food storage and expiration, appropriately drying dishes, removing dented cans of food and ensuring beard guards are worn upon kitchen entry as appropriate. All inservicing will be completed by 10/16/2024. Any dietary staff that have not completed the inservice education by	

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F 812	Continued From page 40 island dressing with best by date of 10/29/22 were found inside the refrigerator in the dining room at the Main Hall. An interview with the DM on 09/23/24 at 12:54 PM stated the refrigerator in the dining room was not monitored or observed by the dietary. He stated he was not aware who was responsible for that refrigerator. He stated he had only been at the facility for 3 months and was still learning his duties. A follow-up interview with the DM on 09/24/24 at 12:50 PM revealed one resident ordered food items online and placed them inside the refrigerator and would get upset if his food items were thrown away. f. During an observation on 09/24/24 at 12:08 PM, NC #1 was observed doing food temperatures without a beard guard. NC #1 had hair covering his jaws, around the mouth and chin. The DM was observed without a hair net or beard guard. The DM's head was shaven, and he had hair covering around his mouth and chin. NC #2 was wearing a hair net but had no beard guard. NC #2 has hair covering his chin. Both the DM and NC #2 were standing by the steam table while the cook was plating food. An interview with the DM on 09/24/24 at 1:05 PM revealed that hair nets were available for staff to use as they walked into the kitchen. The DM verbalized he did not wear a beard guard if he was not near food. NC #2 verbalized he thought a certain length of beard would require the use of beard guards. During an interview on 09/25/24 at 2:15 PM, the	F 812	10/15/2024 will receive education prior to their next scheduled work date. Any newly hired dietary staff members hired after 10/16/2024 will receive education during orientation prior to start of their first shift. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: " The facility licensed Nursing Home Administrator and the Dietary Manager will audit food storage areas, dish drying techniques, expiration dates for food product, and compliance with beard guards 5 times per week x 4 weeks. " All audits will be taken to Quality Assurance Performance Improvement monthly x1 month and discussed with the Interdisciplinary team (IDT) members. IDT team will determine at that time the need for continued monitoring.	

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F 812	Continued From page 41 Administrator verbalized the DM had only been with the facility for a couple of months. The Administrator stated the pimiento spread was not on the facility's menu and there was a resident that preferred pimiento spread for sandwiches. She said it was an oversight of the kitchen staff for not throwing out the pimiento spread.	F 812		
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain the grounds surrounding one of two trash dumpsters free of broken equipment and to keep the grease trap surrounding area clean and free from debris. These failures had the potential to impact sanitary conditions and to attract pests and rodents. The findings included: An observation of the dumpster area was conducted on 09/24/24 at 12:53 PM with the Dietary Manager (DM). The trash observed around one of two dumpsters were the following: - dirty linen/cart containing cardboard boxes, plastic bags, rinse aid pail with cover - one recliner - 4 folded wheelchairs - Four, 15-gallon plastic containers - bleach, laundry detergent, fresh liquid alkali (concentrated laundry builder that prepares the fabric for the washing process), liquid detergent - 2 ½ wooden pallets resting on the building wall	F 814	" Problem Statement: It was alleged that on 9/24/24 during their annual recertification survey, the facility failed to maintain the grounds surrounding 1 or 2 trash dumpsters free of broken equipment and to keep the grease trap surrounding area clean and free from debris. " The facility licensed nursing home administrator is responsible for implementing this plan of correction. " On 9/25/2024 the grounds around the identified dumpster were made free of broken equipment and garbage and the grease trap area was cleaned by the Maintenance Director. " The Maintenance Director completed an audit of the dumpster area on 9/26/2024 and no additional equipment or garbage was found around eth dumpster or grease trap. The Maintenance Director and Certified Dietary manager were in-serviced on 9/26/2024 by the Administrator related to the requirement of the dumpster and grease trap area to free	10/23/24

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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
F 814	Continued From page 42 - one stainless steel rack - 3 wooden planks resting on the building wall An observation of the grease trap was conducted on 09/24/24 at 1:00 PM with the DM. The area surrounding the grease trap included old cardboard, paper towels, cellophane wrappers, plastic lids, pine straw, cigarette butts and food scraps. During an interview with the DM on 09/24/24 at 1:05 pm, the DM stated he was aware of the items around the dumpsters and the grease trap but stated he did not know who to report the issue to nor was he aware that it was his responsibility to ensure the areas were maintained. An interview was completed on 09/25/24 at 2:15 PM with the Administrator. She verbalized that the DM had only been with the facility for a couple of months. The Administrator stated the facility would have done something different if they knew that broken equipment was out there. The Administrator verbalized that it was an oversight on their part.	F 814	from garbage, equipment and debris. " Education began 10/11/24 with all staff including Dietary, Nursing, Housekeeping and contract staff by the Staff Development Coordinator and Assistant Director of Nursing related to maintaining the dumpster and grease trap area clean and free of equipment and debris. Any staff who have not worked or are newly hired staff or contract staff will be trained by the Staff Development Coordinator prior to working their first shift. " The Maintenance Director or Certified Dietary Manager will complete an audit of the dumpster and grease trap area 3 times per week for 4 weeks to ensure compliance. If an issue is found the Dietary and Nursing staff responsible will be reeducated immediately. The audit tool will be brought to the Quality Assurance Committee monthly for 3 months by the Maintenance Director to ensure compliance.	