STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Immediate Jeopardy (IJ)-Removed: A recertification and complaint survey was conducted from 7/16/17 through 7/21/17. Immediate Jeopardy was identified at: CFR 483.13 at tag F224 at a scope and severity (J) CFR 483.25 at tag F323 at a scope and severity (J) CFR 483.75 at tag F490 at a scope and severity (J) The tags F224 and F323 constituted Substandard Quality of Care. Immediate Jeopardy began on 07/18/17 and was removed on 7/21/17. An extended survey was conducted.	F 000		
F 157 SS=G	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or	F 157		8/11/17

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

Electronically Signed | 08/09/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 157	Continued From page 1 clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on observations, staff and physician interviews and record review, the facility failed to notify the physician for a change in condition of a urinary catheter insertion site (urethra) for 1 (Resident #20) of 1 residents reviewed for urinary catheters. The findings included:	F 157	Resident #20□s physician was notified of the change of condition to the resident□s penis on 8/7/17. There are no other residents in the facility with a urinary catheter. The Nurse Aides will be in-serviced on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 157	Continued From page 2 Resident #20 was admitted on 11/22/16 with cumulative diagnoses of Parkinson ' s Disease, Cerebrovascular Disease, urinary retention, and history of urinary tract infections. A review of Resident #20 ' s skin assessment on admission dated 11/23/16 read no areas of concern to his urethra. A review of Resident #20 ' s weekly skin assessment dated 04/24/17 read his had been showered and no skin issues noted. There was no mention of any areas of concern to Resident #20 ' s penis or urethra. A nursing note dated 5/16/17 at 10:44 PM read Resident #20 was sent to the hospital and admitted with hematuria and a UTI. He returned to the facility on 5/21/17. A review of his re-admission skin assessment dated 5/21/17 read no areas of concern to his urethra. A review of a PA progress note dated 6/7/17 read Resident #20 was seen for follow up after his course of antibiotics for a UTI. Staff reported a thick milky looking urine. His GU assessment read he had an indwelling urinary catheter with a large amount of sediment but no blood and the urine was described as yellow. There was no mention of staff concerns related his urethra or penis. A review of Resident #20 significant change MDS dated 6/8/17 indicated his Brief Interview for Mental Status (BIMS) of 2 meaning severe cognitive impairment with no behaviors. He was	F 157	urinary catheter care by the Director of Nurses and Regional Nurse Consultant by 8/11/17 to include retracting the foreskin if needed, clean the penis, clean the urethra, and clean the catheter from top to bottom holding and not putting tension on the catheter. Rinse, dry gently and secure catheter with leg strap. Hanging the catheter bag appropriately and notify the charge nurse of any changes. The nurses will be educated by the Director of Nurses and Regional Nurse Consultant by 8/11/17 on documentation of change of condition with notification to physician and responsible party. The 24 hour nursing report will be reviewed daily by the Director of Nurses/Unit Manager for all changes of condition and will be reviewed in daily morning clinical meeting with the administrator for physician and responsible party notification. The Director of Nurses will take all issues and concerns related to physician and responsible party notification to the monthly Quality Assurance Committee monthly for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 157	Continued From page 3	F 157		

coded for extensive assistance with all his activities of daily living (ADLs) and coded as having a urinary catheter. The Care Area Assessment for his urinary catheter referred reader to his care plan.

A review of Resident #20 ' s care plan dated 6/8/17 read the following problem:
*Resident #20 had a urinary catheter due to urinary retention and prostate cancer. Resident #20 had a history of stretching his tubing in attempts to stand or move about. He needed staff assistance with his catheter care and urinary bag emptying. He had a history of frequent UTI ' s.

Interventions included:
*Observation of Resident #20 ' s skin daily for irritation and redness
*Ongoing assessment of the color and clarity of his urine
*Assessment of Resident for sign of a UTI
*Assistance with his perineal care as needed
*Refer Resident #20 to a Urologist as needed
*Provide catheter care as ordered and as needed
*Change his catheter as ordered
* Obtain Urinalysis and give antibiotics as ordered
*Ensure the catheter tubing is secured to his thigh

A nursing note dated 6/21/17 at 10:13 AM read Resident #20 removed his urinary catheter and it was lying at his bedside. The urinary catheter was replaced without difficulty. There was no documented evidence of trauma of assessment of his urethra or that it was reported to the physician.

In an observation and interview on 7/18/17 at 10:23 AM, Nursing Assistant (NA) #13 stated she had worked at the facility for 3 months. NA #13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 157	Continued From page 4	F 157		

pulled back Resident #20 ' s sheet. There was no observed anchoring device to either thigh. She stated she was not aware that his urinary catheter should be anchored to his thigh. She stated she was instructed to make sure his urinary bag was attached to his bed but not aware that his urinary bag should not be lying on the floor. NA #13 stated in the past when she was assigned Resident #20 she was only instructed to empty his urinary bag. She was not aware of how to perform his urinary catheter care or what to report to the nurse.

In an interview on 07/18/17 at 10:38 AM, Nurse #2 stated she had observed blood in in his urine on occasion. Nurse #2 stated the aides clean his catheter and she assessed his catheter daily to ensure there were no concerns. Nurse #2 stated the aides had not told her that his catheter was not anchored and not told her about any observed concerns to his penis or urethra. Nurse #2 stated if the aides reported or she observed any changes in the appearance of Resident #20 ' s urethra, it should be reported to the physician.

In an interview on 07/18/17 at 3:30 PM, Nurse #1 stated she started in January of 2017 and was assigned Resident #20 on 7/17/17 and thought he did not have a leg strap because it irritated his leg. She stated she did not assess his catheter insertion site or penis but expected the aides to report anything unusual to her. Nurse #1 stated if the aides reported or she observed any changes in the appearance of Resident #20 ' s urethra, it should be reported to the physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 157	Continued From page 5	F 157		

In an observation and interview on 07/19/17 at 9:30 AM, NA #2 stated she had worked at the facility for one year and she was assigned Resident #20. During an observation of Resident #20 ' s catheter care, she cleaned around his urethra and cleaning his tubing. She did not attempt to clean the entirety of his penis. NA #2 was asked to further reveal his penis by pushing back his testicles and foreskin. Observed was a penile tear extending from the urethra down the underside of the shaft of his penis measuring approximately 2 inches in length. NA #2 stated his penis was not like that when he was admitted in November 2016 and it should be reported to the nurse.

In an interview on 07/19/17 at 9:50 AM, Nurse #2 confirmed she looked at Resident #20 ' s penis daily. She stated she thought he had a small tear on his admission but it did not look like it did today. Nurse #2 stated his catheter was changed monthly on night shift and the penile tear should have been reported to his physician when it was observed during his catheter change.

In an interview on 07/19/17 at 10:50 AM, Nurse #3 stated she worked third shift. She stated she thought Resident #20 had a small tear for "awhile". She described it as a 2 centimeter "ridge" on his penis but she had not observed his penis in probably a month. She stated the other nurse who worked nights usually changed his urinary catheter. She confirmed Resident #20 ' s catheter was documented changed by the other night nurse on 7/17/17 on third shift.

In a telephone interview on 07/19/17 at 3:10 PM, Nurse #6 confirmed she worked nights and worked third shift on 7/17/17. She stated she had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 157	Continued From page 6	F 157		

changed Resident #20 ' s urinary catheter in the past but not recently. Nurse #6 was reminded she documented on his TAR she changed his urinary catheter Monday night on 07/17/17. Nurse #6 stated she did not change his catheter on 07/17/17 as documented. She was unable to offer an explanation as to why she initialed off on the TAR that she changed Resident #20 ' s urinary catheter when on interview, she stated she did not. She stated she thought she changed his urinary catheter a month or so ago and had observed pus and blood at his urethra but had not noted the penile tear. She stated if she observed a tear to Resident #20 ' s urethra, it should have been reported to his physician.

A review of the facility incident logs on 7/16/17 at 4:00 PM from November 2016 to present included no intakes regarding any injury or change in Resident #20 ' s catheter insertion site at his urethra.

In an interview on 7/19/17 at 4:20 PM, NA #14 stated it was her first day back on the 200-hall assignment after a 3-month rotation on another hall. The Director of Nursing (DON) and NA #14 were observed assessing Resident #20 ' s penis. The DON pulled back Resident #20 ' s foreskin and testicles to reveal the penile tear. NA #14 stated "it wasn ' t like that 3 months ago". NA #14 stated he may have had some bleeding and maybe a little split but not like what it looks like now. The DON stated she was unable to recall if it had worsened since she last observed it a "few weeks ago". She stated it was her expectation that it would have been reported to his physician when it was discovered but she would report it today.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 157	Continued From page 7 There were no nursing notes again until 7/19/17 at 4:59 PM which read Resident #20 ' s urinary catheter was changed without difficulty. In a telephone interview on 07/21/17 at 9:45 AM, Resident #20 ' s physician stated it was her expectation that she be notified of any changes such as trauma or tearing to Resident #20 ' s s penis or urethra. In an interview on 07/21/ at 10:40 AM, the Administrator stated her expectations were the same as Resident #20 ' s physician.	F 157		
F 224 SS=J	483.12(b)(1)-(3) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN §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 symptoms. 483.12(b) The facility must develop and implement written policies and procedures that: (b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (b)(2) Establish policies and procedures to investigate any such allegations, and (b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by:	F 224		8/18/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 224	Continued From page 8 Based on observations, interview with facility staff, physician and Administrator and records review the facility failed to prevent an avoidable fall from mechanical lift resulting in injury for 1 of 6 residents reviewed for accidents and falls [Resident # 47]. On 4/19/17 Resident # 47 who was severely cognitive impaired had a fall with injuries while being weighed by mechanical lift, with only one person assist. The resident's care plan and facility policy indicated two (2) person assist for transfer when using a lift. Resident # 47 had a laceration to her head, C1 Jefferson fracture and Type 2 odontoid fracture due to the fall. Resident # 47 expired on 5/13/17. Immediate Jeopardy began on 4/19/17 at 2:30 AM when the sling's four straps were not all unhooked before the sling was removed from the resident. This caused the resident to be pulled into the floor. The immediate jeopardy was removed on 7/21/17 at 12:30 PM when the facility's acceptable credible allegation of compliance was verified. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to allow the facility time for therapy or licensed nurse to assess all residents for determination of the safest mechanical lift device using the lift assessment evaluation, Lift assessment evaluation to be completed by the rehab director, resident's care plan and care guide. Findings included: Resident was admitted to the facility on 7/25/12 and on readmit date on 5/7/14, with documented	F 224	Resident #47 no longer resides in the facility. All other residents as having the potential to be affected by the use of the mechanical lift had their transfer status re-assessed by the DON and MDS coordinator on 7/18/17 for the need for the mechanical lift. Care plans and care guides were updated by the MDS coordinator to indicate 2 person assist and transfer for those requiring the mechanical lift. On 4/20/17 and 4/21/17 the nurse aides were re-educated on the use of the mechanical lift and skills observations completed by the Rehab Director. The nurse aides will be trained by the therapy department on the use of the lifting device upon hire and annually to show continued competency on the lifting device. The direct care staff to include full time and part time staff was re-educated by the administrator on 7/18/17 on the importance of reviewing the care guide daily for updates and to understand the expected outcome of the residents care. Staff will not be permitted to work until in-service's are complete. Care guides for each resident are located on the inside of their closet door. Upon hire the direct care staff will be educated on care guides, its purpose and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 224	Continued From page 9 diagnosis of Non Alzheimer's Dementia, history of falls, Dysphagia, Other osteoporosis without current pathological fracture, lack of coordination, and abnormalities with gait and poly osteoarthritis. Review of the Quarterly Minimum Data Set (MDS) dated 4/10/17 revealed admission date 5/7/14. Resident was coded as minimum hearing, unclear speech and rarely /never make self-understood. Resident was severely cognitively impaired. Resident was coded as total dependent and needing two person assist with bed mobility, transfer and bathing, one person assist with dressing, eating, toileting and personal hygiene. Resident was having functional limitation impairment for both sides of lower extremity. MDS indicated resident was not on any pain medication. Resident was coded as being on mechanical altered, therapeutic diet. Review of the care plan dated 4/18/17 revealed problem area with onset date 1/13/17- "Requires total assist with Activities of Daily living (ADL). Resident has diagnosis of Alzheimer's dementia, alert and non-verbal, gets up to a care foam chair and requires staff to propel. The goal stated that -will minimize potential for significant decline in ADL status. The interventions stated resident was a two (2) assist transfer with the total lift. Geri sleeves to bilateral arms as orders and resident to wear orthotic and hip abduction braces as ordered with routine skin checks. On Observation and reviewing the manual of the mechanical lift, the lift has the capability to record weights. Review of nursing notes dated 4/19/17 read in part: resident was been weighted by Nurse Aide	F 224	their location. On 7/19/17 in-services began for all staff to include full time and part time staff in all departments and they were re-educated on the facility□s abuse/neglect policy by the administrator and Director of Nurses's and the education included to follow the care plan and care guide for each individual resident and was completed on 7/24/17. A 24 hour initial report was completed by the administrator and sent to North Carolina Division of Health and Human Service/Health Care Personnel Investigation on 7/20/17. A 5 day report was completed 7/26/17 and sent to North Carolina Division of Health and Human Service/Health Care Personnel Investigation by the administrator (HCPI). The HCPI has a scheduled visit for 8/9/17 for their investigation. Upon any reports of abuse/neglect the administrator/DON will report any allegations to HCPI within the 2 hour/24 hour time frame. Any reportable allegations will be reviewed by the V.P. of Operations/Regional Nurse Consultant and in addition the reports will be reviewed in monthly Quality Assurance (QA) Committee for 3 months and the quarterly Executive QA Committee for continued quality improvement.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 224	Continued From page 10	F 224		

(NA). When putting resident on bed, NA undid three (3) loops not all four (4) from lift. Resident was pulled to the floor and bumped her head to the roommate's bed rail when the lift was moved. Resident was sent to Emergency Room (ER) for treatment and evaluation. Nurse Practitioner (NP) and responsible party was notified.

Review of the incident report dated 4/19/17 read in part - NA #9 was weighing resident when putting the resident on bed undid (3) loops not all four (4) from lift. When NA moved the lift, resident was pulled to floor and bumped head on roommate's bed rail. Resident has laceration to top of head due to amount of blood could not assess wound properly. Pressure applied to the wound on the head.

Review of Emergency Medical Services (EMS) report 4/19/17 at 2:28 PM read in part: Patient on floor lying supine. Nurse reported resident was being transferred from wheelchair to bed, fell and hit head. Neck pain to palpation due to fall from bed 3 feet (ft). Neck pain on palpation and tender spine and paraspine. Immobilized to hospital.

Review of ER report dated 4/19/17 at 3: 05 PM read in part: Patient in ER, lift broke and patient fell, sustained a laceration on top of scalp. Diagnosis: posterior displacement of second cervical vertebra (type 2 odontoid fracture) and non-displaced fracture of first cervical vertebra, and possible compression of upper cervical cord.

Hospital admission note dated 4/19/17 at 10:18 PM read in part - Resident was admitted to Medical Center. Hospital admission note indicate that resident was transferred from Hospital via EMS with a first cervical vertebra (C1) Fracture.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 224	Continued From page 11	F 224		

Patient was sent to hospital from her nursing home after sustaining a fall from a mechanical lift. Unknown if there was loss of consciousness (LOC). She fell from a height of 3 to 5 ft and point of impact was the head and neck. Patient makes only incomprehensible sounds and was unable to follow command. Per EMS was her normal mental status. She has a laceration to the top of her head. Point of impact head and neck.

Review of ED Provider note dated 4/19/17 at 10:46 PM read in part- accident occurred 6- 12 hours ago. Fall occurred at Skilled Nursing Facility (SNF) from Mechanical lift. She fell from a height of 3 to 5 ft. and point of impact head and neck. Clinical impression - Closed displaced fracture of first cervical vertebra, unspecified fracture morphology.

Review of Orthopedic Note dated 4/19/17 at 10:48 PM read in part: patient was seen at an outside hospital where she was found to have first cervical vertebra fracture and second cervical vertebra fracture. Assessment and Recommendation indicated C1 Jefferson fracture and C2 type 2 odontoid fracture. Maintain Miami J (MJ) cervical collar at all times; head of bed (HOB) as tolerated; this injury does not have risk of neurological compromise, however risk associated with surgical interventions have high morbidity. Recommend no acute orthopedic surgical intervention.

Review of Employee Counseling / Discipline Statement dated 4/20/17 revealed NA #9 failed to utilize two staff for use of Mechanical lift for weighing a resident. Corrective actions were 1) in-service on Mechanical lift. 2) Return demonstration of use of Mechanical lift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 224	Continued From page 12	F 224		

Review of the Medical Discharge Summary dated 4/21/17 read in part- Resident blood pressure (BP) remained elevated despite home regime. Hemodynamically stable at discharge and at baseline mental status. Recommended maintain MJ collar at all times.

Review of nursing note dated 4/21/17 read in part: Resident arrived to facility via facility transport at 7:17 PM, MJ collar in place on the neck. Resident stable, alert, nonverbal. Vital signs taken. Resident skin dry and intact with some bruising noted to back of both hands and right lower arm at IV site, respiration even and unlabored . Incontinent of Bowel and Bladder, no acute distress noted, will continue to monitor.

During an interview with Nurse #2 on 7/18/17 at 7:05 AM, nurse indicated NA #9 was assigned residents weights the day of the incident. Nurse stated NA #9 came running to her and informed her about Resident #47 fall, unsure of time (may be before or after lunch). Nurse stated Resident #47 was examined by EMS upon arrival and transported her to the hospital in a stretcher. Nurse #2 further stated that two (2) people were required when using the mechanical lift and was unsure why NA #9 was working alone with the mechanical lift while weighing the residents.

During an interview with the NA #9 on 7/18/17 at 11:38 AM, NA indicated she was usually assigned weights for the residents. She indicated on the day of the incident, she was using a mechanical lift to weigh Resident # 47. NA #9 stated the resident was placed on the pad and hooked, lifted up to be weighed. After the weight was taken the resident was lowered down on the bed. NA #9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 224	Continued From page 13	F 224		

stated she had unhooked three (3) of the four (4) clips and when the resident's roommate family member walked in, she was distracted. She stated she responded "patient care" and after he left, NA stated she thought she had removed all of the four (4) hooks from the pad and moved back. NA #9 stated at this point she felt a tug and she could not reach the resident as resident was fallen down. She stated she immediately called the nurse for assessments. NA #9 stated she was working alone with the Mechanical lift that day. She indicated facility had other NA, but she just did not ask for assistance. She also stated she usually works alone with weights and Mechanical lift as she was assigned to that duty for a long time. NA #9 indicated that she only asks for help if the resident was combative or a heavy weight person.

During an interview with the administrator on 07/21/2017 at 10:41 AM, Administrator indicated the staff should follow the care plan and by not using two (2) person for Mechanical lift it was a neglect.

On 7/18/17 at 2:30 AM the administrator, corporate nurse consultant, corporate vice president were informed of immediate jeopardy. The Administrator provided an acceptable credible allegation of compliance on 7/21/17.

Allegation of Compliance: F 224

On 4/19/17 at 2:15 PM the resident was positioned in the Hoyer lift over her bed at approximately 6 inches above the mattress for the purpose of obtaining her weight. After getting the residents weight the c.n.a. returned the resident to the mattress and started unhooking

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 224	Continued From page 14	F 224		

the 4 hooks that held the pad onto the lift. After unhooking 3 of the 4 hooks a visitor entered the room and the c.n.a. stated out "resident care" and the visitor left the room. The c.n.a. turned back to the resident she was weighing and at this point started to pull the mechanical back from the bed. The c.n.a. had forgotten that she had not undone the fourth hook and the resident had started to roll and fell from the bed. The c.n.a. was distracted by the visitor coming into the room causing her not to undo the fourth hook. The c.n.a. did not have a second person to assist with the mechanical lift because she stated she was not transferring the resident and this was her common practice for obtaining weight for this resident.

The conclusion of the root cause, if following the policy the c.n.a. would have had a second staff while using the mechanical lift per the policy of the facility. The second staff member could have told the first c.n.a. that the fourth hook was still attached prior to moving the mechanical lift and could have prevented the fall.

On 4/19/17 at 2:15 PM while obtaining the residents weight the employee pulled the Hoyer lift without unhooking all 4 hooks causing the resident to fall from the bed hitting her head and obtained a laceration on the top of her head.

The physician and family was notified on 4/19/17 at 2:30 PM and the resident was sent to the emergency room for evaluation and admitted for observation and returned to the facility on 4/21/17 with a diagnosis of C1 fracture . The resident expired on 5/13/17.
The involved staff was counseled on 4/20/17 by the Administrator for not utilizing 2 staff members

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 224	Continued From page 15	F 224		

when using the Hoyer lift while weighing a resident and re-inserviced on use of the Hoyer lift by the Rehab Director, with return demonstration of using a Hoyer lift on 4/20/17.

On 4/20/17 and 4/21/17 the CNAs were re-educated on the use of the Hoyer lift and skills observations completed by the Rehab director.

Other residents identified as having the potential to be affected by the use of mechanical lifts, transfer status was reassessed by the DON and MDS coordinator on 7/18/17 for the need for the Hoyer lift and the care plans and care guides were updated to indicate 2 person assist and transfer for those requiring a Hoyer lift.

The transfer status of all residents will be reviewed quarterly with the scheduled MDS and as needed. The Rehab Director will complete the lift assessment on admission and as needed and give to the MDS Coordinator to update the Care Plan and Care Guides. The MDS Coordinator will convey changes to the care guides at morning meeting and the changes will be placed on the 24 hour report for the following shifts each morning after daily morning clinical meeting. The following shifts will then communicate the changes to the c.n.a.'s for their individual residents. The charge nurse will monitor the c.n.a.'s to ensure that the care guides are followed. Any deviation from the care provided according to the care guides will be reported to the DON to be investigated for possible neglect.

The Certified Nursing Assistant will be trained by the therapy department on the use of the lifting devices upon hire and annually to show continued competency on the lifting device.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 224	Continued From page 16 On 7/18/17 all other residents with the potential to be affected for use of a mechanical lift have been identified on their care plans. All staff were re-educated on the use of the mechanical lift policy on 4/20/17 and 4/21/17 by the Rehab Director. A 24 hour initial report was completed on 7/20/17 and sent to N.C. Division of Health and Human Services/Health Care Personnel Investigations by the administrator. The direct care staff was re-educated on 7/18/17 by the administrator on the importance of reviewing the care guide daily for updates and to understand the expected outcome of the residents care. Care guides for each resident are located on the inside of their closet door. On 7/19/17 in-services began for all staff in all departments and were re-educated on the facility's abuse/neglect policy by the Administrator and DON and the education included following the care plan and care guide for each individual resident to be completed by 7/24/17. The immediate jeopardy was removed on 7/21/17 at 12:30 PM when interviews with nurse aides confirmed they had received in-service training on the use of mechanical lift, importance of reviewing of care guides and also re-educated on facilities abuse and neglect policy. The facility will remain out of compliance at a lesser scope and severity.	F 224		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		8/18/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 241	Continued From page 17 (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to provide a dignified dining experience for 2 of 2 residents (Resident # 71 and Resident # 9) that were not provided with their meals at the same time as the other residents in 1 of 2 dining rooms during 2 meal observations. The facility failed to provide 4 of 4 residents (Resident #33, Resident #19, Resident #61 and Resident #40) that received thickened liquids and supplements a glass to drink these beverages out of during 2 meal observations. The residents were observed drinking their beverages directly out of the plastic and paper containers that they were packaged in by the manufacturer. Findings Included: 1. During a dining observation on 7/16/17 at 5:20 pm of the assistive dining room there were 6 residents in the dining room. At 5:20 pm 5 residents were observed being assisted with their meal by staff members. Resident # 71 was sitting in the dining room at 5:20 pm but did not have her meal. At 6:05 pm another cart was delivered to the nursing unit and at 6:10 pm Resident #71 received her meal tray. She was observed to feed herself after her meal tray was prepared for her. During a dining observation on 7/19/17 at 12:45 pm of the assistive dining room there were 4 residents in the dining room that were being	F 241	Resident #71 has been moved to the main dining room for meals. Resident #9 will remain in the assisted dining room. The Dietary, Activity and Nursing staff was in-serviced by the Registered Dietician on 8/14/17 on dignity and dining service to include all drinks and supplement drinks being served in the appropriate drinking cup and not in the packaged container. Also included in the in-service was all residents will be served at the same at a table and also both residents in a room. Any changes in the dining room assignment will be reviewed on an ongoing basis in weekly PAR meeting. Dietary Manager will complete dining observations of residents being served at the same time at the same table to include dining with dignity, all drinks and supplements served in appropriate drinking cups. The dining observation will be completed 2 times a week for 1 month, then weekly for 1 month, monthly for 3 months. All issues identified will be brought to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 241	Continued From page 18 assisted with their meals. An observation from 12:45 pm until 1:10 pm of Resident #71 revealed she wheeled herself into the assistive dining room and the staff removed her from the dining room into the hallway. Resident #71 was observed to continue to wheel herself back in the dining room multiple times and the staff kept taking her back into the hallway. An interview with the Speech Therapist, who was assisting a resident with their meal in the assistive dining room, on 7/19/17 at 1:00 pm revealed the staff were told yesterday not to let residents into the dining room until their meal tray had been delivered. The ST explained Resident #71 ' s meal tray came out on a later cart. She stated Resident #71 could feed herself with tray set-up and should be scheduled to eat in the main dining room. An interview on 7/20/17 at 11:45 am with the Dietary Manager (DM) revealed he was working on getting the residents meal trays arranged in the correct order so that resident ' s trays were served on the right cart and they could be served at the same time. An interview on 7/21/2017 at 11:26 am with the Administrator revealed it was her expectation that all residents were served their meals at the same time and that residents were not just sitting there watching other residents eat. 2. a) During a dining observation on 7/16/17 at 5:48 pm Resident #33 was eating in the assistive dining room. His meal tray contained 2 - 4 ounce (oz.) containers of nectar thick tea. He did not have a glass or a straw to drink the beverages out of. He was observed drinking directly from the	F 241	Quality Assurance by the Dietary Manager. Other residents potentially affected was audited/assessed by the Dietary Manager on 8/8/17 to assess dining room assignment with changes made per resident□s needs. The changes will be reviewed in Patient at Risk (PAR) meeting weekly and follow up review in monthly QA committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 241	Continued From page 19	F 241		

4 oz. plastic container that the thickened tea was packaged in.

b) During a dining observation on 7/19/17 at 12:15 pm of the main dining room Resident #19 was observed eating her lunch. She had 1 - 4 oz. container of honey thick tea and 1 - 4 oz. container of honey thick water. She did not have a glass or a straw to drink the beverages out of. She was observed to be drinking directly out of the 4 oz. plastic containers that the thickened beverages were packaged in.

c) During a dining observation on 7/19/17 at 1:00 pm of the assistive dining room Resident #61 was observed eating her lunch. She had 1 - 4 oz. container of nectar thick tea and 1 - 4 oz. container of a health shake. She did not have a glass or a straw to drink the beverages out of. She was observed to be drinking the thickened tea directly out of the 4 oz. plastic container it was packaged in and drinking the health shake directly out of the 4 oz. paper container it was packaged in.

d) During a dining observation on 7/19/17 at 1:15 pm of the assistive dining room Resident #40 was observed eating her lunch. She had 1 - 4 oz. container of nectar thick tea and 1 - 4 oz. container of a mighty shake. She did not have a glass or a straw to drink the beverages out of. She was observed to be drinking the thickened tea directly out of the 4 oz. plastic container it was packaged in and drinking the mighty shake directly out of the 4 oz. paper container it was packaged in.

An interview on 7/18/17 at 12:46 pm with Nursing Assistant (NA) #6 revealed that not all residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 241	Continued From page 20	F 241		

on thickened liquids received a glass to drink them out of. She stated some residents received a red nosey cup to drink out of, but she didn ' t think they had enough cups for everyone to receive one.

An interview on 7/19/17 at 1:18 pm with the Speech Therapist revealed she thought it would be good if all residents that received thickened liquids also received a glass to drink them out of. She stated that the plastic ridge of the thickened liquid containers could be a little sharp. She stated the residents on thickened liquids didn ' t receive straws.

An interview on 7/20/17 at 11:45 am with the DM revealed he had not really thought about the residents on thickened liquids or those receiving shakes did not have a glass to drink out of. He stated it would be better if they were provided with glasses since residents on thickened liquids were not provided with straws.

During an interview on 7/21/17 at 11:26 am with the Administrator she stated it would be more home like for residents to drink their thickened liquids and shakes out of a glass and a glass should be available.

Resident #9 was admitted to the facility on 7/20/10 with documented diagnosis of Alzheimer's disease, Stiffness of left knee, Transient cerebral ischemic attack, Dysphagia, Pressure Ulcer Unstageable heel and Dementia. Resident on comfort care.

Review of the Quarterly Minimum Data Set (MDS) dated 7/2/17 revealed admission date

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 241	Continued From page 21	F 241		

7/20/10. Resident was coded as adequate hearing, unclear speech, rarely makes self-understood. Resident was coded as severely impaired cognitive skills with a Brief Interview for Mental Status (BIMS) score of 0. Resident was coded as total dependence with two person assist for bed mobility, transfer, and personal hygiene. Extensive two person assist with dressing, eating, and toilet use 3/3. Resident was coded as always bladder and bowel incontinence. Resident was coded as receiving mechanically altered diet.

Review of the revised care plan dated 1/13/17 revealed problem area: Potential for weight loss related to leaving 25 percent (%) or more food uneaten at most meals. Resident on mechanical soft diet with pureed meals and requires to be fed at all meals..

During lunch observation on 7/17/17 from 12:35 PM to 12:45 PM, observed Resident # 9 sitting in a geriatric chair in the assisted dining hall. Resident #9 was observing other residents been assisted with their meals. Resident #9 was not served any tray.

During an interview with Nurse # 2 on 07/17/2017 at 12:45 PM Nurse stated that resident #9 had not consumed her meals. She indicated Resident #9 meal tray was served on the second assistant cart. She stated the first assisted meal cart serves meals to resident who needed assistance, while the second cart that arrives 15 - 20 minutes later has trays for resident who need feeding assistance and eats slowly. She stated residents were brought in the dining hall according to their feeding schedule. She further stated that as the room was used for activities this morning the resident continues to stay in the room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 241	Continued From page 22 On 7/17/17 at 12:40 PM, observed Nurse #2 call a Nurse Aide (NA) and asked the NA to move the resident from the dining hall. NA pushed the geriatric chair into the hallway. Resident #9 looked distressed when she was moved to the hallway near the nursing station. Resident #9 was alert and was unable to communicate her needs. The second cart arrived at 1:00 PM and Resident #9 was observed been fed by staff. During an interview with the Dietary Manager (DM) on 7/20/17 at 11:45 AM, DM indicated he was working on the resident's meal trays delivery so that that resident's trays were served on the right cart and served at the same time. During an interview with the administrator on 7/21/17 at 10: 40 AM Administrator indicated that she was not aware of the situation and that the resident meal time would be revisited and changes accordingly.	F 241		
F 282 SS=G	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure a care planned intervention for securing a urinary catheter to	F 282	Resident #20 had a urinary catheter thigh strap applied on 7/21/17. His catheter bag was repositioned to not touch the floor.	8/11/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 282	Continued From page 23 prevent injury for 1 of (Resident #20) 1 reviewed for urinary catheters. Findings included: Resident #20 was admitted on 11/22/16 with cumulative diagnoses of Parkinson ' s Disease, Cerebrovascular Disease, urinary retention, and history of urinary tract infections. A review of his re-admission skin assessment dated 5/21/17 read no areas of concern to his urethra. A review of Resident #20 significant change Minimum Data Set (MDS) dated 6/8/17 indicated his Brief Interview for Mental Status (BIMS) of 2 meaning severe cognitive impairment with no behaviors. He was coded for extensive assistance with all his activities of daily living (ADLs) and coded as having a urinary catheter. The Care Area Assessment for his urinary catheter referred reader to his care plan. A review of Resident #20 ' s care plan dated 6/8/17 read the following problem: *Resident #20 had a urinary catheter due to urinary retention and prostate cancer. Resident #20 had a history of stretching his tubing in attempts to stand or move about. He needed staff assistance with his catheter care and urinary bag emptying. He had a history of frequent UTI ' s. Interventions included: *Ensure the catheter tubing is secured to his thigh A review of Resident #20 ' s undated care guide did not include the intervention of ensuring the catheter tubing is secured to his thigh. In an observation on 07/17/17 at 9:00 AM,	F 282	There are no other residents with a urinary catheter, therefore there are no other potential residents affected. Nursing staff was in-serviced by the Director of Nurses/Regional Nurse Consultant by 8/11/17 on applying a catheter strap to relief tension of the catheter tubing and maintaining the catheter bag off the floor. Resident #20 will have catheter care and catheter tubing will be secured to the thigh using a leg strap and assessed every shift and documented on the Treatment Record (TAR) by the assigned nurse to ensure the care plan is being followed. The direct care staff was re-educated by the administrator on 7/18/17 on the importance of reviewing the care guide daily for updates and to understand the expected outcome of the residents care. Care guides for each resident are located on the inside of their closet door. Upon hire the direct care staff will be educated on care guides, its purpose and their location. The nurse aides will use the care guide for communication of care needs regarding catheter care and catheter tubing securement. Residents with urinary catheters will be reviewed in PAR weekly to ensure appropriate documentation is in place. The Director of Nurses/Unit Manager will report findings to the monthly Quality Assurance committee for 3 months for continued quality improvement.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 282	Continued From page 24	F 282		

Resident #20 was lying in a low bed with urinary catheter bag attached to the right side of his bed frame resting on the floor.

In an observation on 07/17/17 at 12:10 PM, Resident #20 was lying in a low bed with a sheet partially un-obstructing the view of his right and left thighs. There was no observed catheter securement device to either thigh, the urinary catheter was attached to the right side of the bed frame with the bag resting on the floor. There was no observed blood in the urinary tubing but his urine appeared pale yellow with white sediment.

In an observation on 07/18/17 at 10:21 AM, Resident #20 was lying in a low bed. His catheter bag was attached to the left side of his bed frame resting on the floor. There was observed blood tinged urine in his catheter tubing.

In an observation and interview on 7/18/17 at 10:23 AM, Nursing Assistant (NA) #13 stated she had worked at the facility for 3 months. NA #13 pulled back Resident #20 ' s sheet. There was no observed anchoring device to either thigh. She stated she was not aware that his urinary catheter should be anchored to his thigh. She stated she was instructed to make sure his urinary bag was attached to his bed but not aware that his urinary bag should not be lying on the floor. NA #13 stated in the past when she was assigned Resident #20 she was only instructed to empty his urinary bag. She stated she used the care guide inside his closet door for how to care for Resident #20.

In an interview on 07/18/17 at 10:38 AM, Nurse #2 stated the aides clean his catheter and she assessed his catheter daily to ensure there were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 282	Continued From page 25	F 282		

no concerns. Nurse #2 stated the aides had not told her that his catheter was not anchored.

In an interview on 07/18/17 at 3:30 PM, Nurse #1 stated she started in January of 2017 and was assigned Resident #20 on 7/17/17 and thought he did not have a leg strap because it irritated his leg.

In an observation on 7/18/17 at 3:40 PM, Resident #20 was lying in a low bed with his urinary catheter bag attached to the right side of his bed frame resting on the floor

In an observation and interview on 07/19/17 at 9:30 AM, NA #2 stated she had worked at the facility for one year and she was assigned Resident #20. During an observation of Resident #20 ' s catheter care, there a leg strap securing his urinary catheter tubing to his right thigh. During an observation of Resident #20 ' s catheter care, she cleaned around his urethra and cleaning his tubing. She did not attempt to clean the entirety of his penis. NA #2 was asked to further reveal his penis by pushing back his testicles and foreskin. Observed was a penile tear extending from the urethra down the underside of the shaft of his penis measuring approximately 2 inches in length. NA #2 stated his penis was not like that when he was admitted in November 2016.

In an interview on 07/19/17 at 9:50 AM, Nurse #2 stated she applied a leg strap to Resident #20 ' s leg yesterday around 11:00 AM on 7/18/17.

A nursing note dated 7/20/17 at 8:15 AM read Resident #20 ' s urinary catheter tubing was secured in place with a leg strap.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 282	Continued From page 26 In an interview on 7/20/17 at 2:40 PM, the MDS nurse stated she completed Resident #20 ' s last care plan revision on 6/8/17. She stated she did not verify there was an updated care guide in Resident #20 ' s closet including the intervention of securing his urinary catheter was secured to his thigh. In a telephone interview on 7/20/17 at 11:45 AM, the Urologist who saw Resident #20 on 6/26/17 stated some penile erosion was expected from long term urinary catheter however a 2-inch tear would have been the result of trauma or the staff not ensuring the use of a leg strap to prevent the weight of the urinary bag tugging on his catheter. In a telephone interview on 07/21/17 at 9:45 AM, Resident #20 ' s physician stated it was her expectation that Resident #20 ' s urinary catheter be secured to prevent tension and possible trauma or penile erosion. In an interview on 07/21/ at 10:40 AM, the Administrator stated her expectation the staff followed the care plan and the care guide include the intervention of securing his urinary catheter to his thigh using a leg strap to prevent tension or injury.	F 282		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest	F 309		8/18/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 309	Continued From page 27 practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (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 observation, record review, resident interview and staff interviews the facility failed to provide a fluid restriction as ordered by the physician for 1 of 1 resident (Resident #62) that was reviewed for dialysis. Findings included: Resident #62 was admitted to the facility on	F 309	Resident #62 no longer resides in the facility. There is one resident in the facility at this time on fluid restriction. Nursing staff will be in-serviced by 8/18/17 on protocol for fluid restriction by the Registered Dietician (RD).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 309	Continued From page 28 3/7/16 and diagnoses included end stage renal disease, dependence on renal dialysis and heart failure. A quarterly minimum data set (MDS) dated 6/11/17 for Resident #62 revealed he received dialysis treatment, was on a therapeutic diet, required supervision with his activities of daily living (ADL ' s) and his cognition was intact. A review of the physician orders for Resident #62 revealed an order was initiated on 1/9/17 for a 32 ounce (oz.) fluid restriction per day, dietary to give 8 oz. fluids with meals and nursing to give 240 cubic centimeters (cc) every shift. An order initiated on 6/21/17 for Prostat 30 milliliters (ml) twice daily and an order initiated on 6/28/17 for 1 can (8 oz.) Nepro every day for a supplement. A care plan for Resident #62 that was updated on 6/19/17 identified he was on hemodialysis due to a diagnosis of renal failure and was at increased risk for fluid deficit related to diuretic use and dialysis. Interventions included to encourage compliance with fluid restriction as ordered, but he is non-compliant with it and monitor residents fluid intake as ordered. A review of the July 2017 medication administration record (MAR) for Resident #62 revealed an entry for 32 oz. fluid restriction in a 24 hour period. The times on the MAR were 6:00 am, 2:00 pm and 10:00 pm and there was a check mark / initials for each of these times. The amount of fluids consumed for each of these time periods was not documented. There was an entry for Nepro 1 can q day at 2:00 pm and there was a check mark / initial for this time. There was an entry for Prostat 30 ml at 1:00 pm and 8:00 pm	F 309	The physicians order for fluid restriction will be verified by the nurse, the order will include the volume or range of fluid permitted during 24 hour period. The Dietary Department will be notified by the nurse using Diet Order/Communication Form, dietary will notify the Registered Dietician to calculate the amount of fluid to be provided on meal trays and noted on the tray card, and will calculate the remaining amount of fluids to be provided by nursing and what is allotted for each shift. The fluid intake will be documented by the nurse on the intake sheet to monitor and document the total fluid intake in a 24 hour period according to physicians order and maintained as long as the resident is on fluid restrictions. The nursing staff will be notified by the care plan and care guide regarding fluid restriction. When a resident is on fluid restriction the resident will be monitored by the RD and any issues identified will be reviewed in weekly PAR meeting and followed up in monthly QA committee for 3 months for continued quality improvement.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 309	Continued From page 29	F 309		

with a check mark / initial for both of these times.

An observation and interview on 7/20/17 with Resident #62 revealed he had a 16 ounce cup that was approximately half full on his bedside table. Resident #62 stated he went to dialysis 3 times per week. He stated he wasn ' t sure if he was on any kind of diet, but the Dietitian at dialysis told him not to eat any bananas. The resident added he is supposed to watch what he drinks. He explained some of the staff bring him water and ice to keep in his room and some don ' t.

An interview on 7/20/17 at 9:50 am with Nursing Assistant (NA) #1 revealed she was familiar with Resident #62. She stated he went to dialysis 3 times a week. The NA was unaware of resident being on any diet or fluid restriction. She added Resident #62 had a water pitcher in his room and he asked for water and ice throughout the day. NA #1 provided additional information that the nurse told her Resident #62 was on a fluid restriction and that was her mistake. She stated she had an assignment sheet for the resident but it didn ' t say he was on a fluid restriction or not to provide him with a water pitcher.

An interview on 7/20/17 at 10:05 am with NA #2 revealed she was familiar with Resident #62. She stated he was on dialysis and was supposed to be on a fluid restriction. NA #2 added she would supply him with a small amount of water and ice during the day. She explained she believed they could give him 360 ccs of fluids on her shift. She stated she recorded how much he drank with his meals or a snack in the computer, but didn ' t record what he drank from his water pitcher.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 309	Continued From page 30	F 309		

The meal percentage roster for Resident #62, provided by the Director of Nursing (DON), was reviewed for 6/19/17 through 7/19/17. The roster included the amount of fluids the resident drank with meals and between meal snacks. It did not include the fluids he drank from his water pitcher, with his medications or his ordered supplements. The roster documented excess of his 32 oz. fluid restriction on the following days: 6/21 - 1080 cc ' s, 6/22 - 1140 cc ' s, 7/3 - 1200 cc ' s, 7/12 - 1700 cc ' s, 7/13 - 1200 cc ' s, 7/16 - 1680 cc ' s and 7/18 - 1440 cc ' s.

An interview on 7/20/17 at 4:38 pm with Nurse #7 revealed she was the nurse for Resident #62. She stated he was supposed to be on a fluid restriction, but he did not always adhere to it. The nurse stated he would ask for extra fluids or go down to dietary and get extra fluids. She reported they didn ' t document how much fluid he drank with med pass or his total fluids for the day. She stated I guess we should be doing that.

An interview on 7/20/17 at 4:51 pm with the Director of Nursing (DON) revealed if a resident was on a fluid restriction they should have parameters for how many fluids the resident could have with their meals and with each shift. She stated the nurses would contact the Registered Dietitian (RD) to determine how the fluid restriction should be allocated for dietary and for nursing. The DON reported she was not aware of the discrepancy of the fluid restriction order for Resident #62. She stated it was her expectation that fluid restrictions were provided according to the physicians order and that a 24 hour total was documented on the MAR.

A review of the meal tray card dated 7/20/17 for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 309	Continued From page 31 Resident #62, provided by the Dietary Manager (DM) revealed he was on a regular, low potassium diet with large portions and a 1000 cc fluid restriction. The meal tray card documented to provide the resident with two 8 oz. glasses of fluid per meal. An interview on 7/21/17 at 8:37 am with Cook #1 revealed that according to Resident #62 ' s tray card he would receive two 8 oz. cups of fluid per meal. An interview on 7/21/17 at 8:39 am with the DM revealed that Resident #62 received two 8 oz. cups of fluid with each meal. He stated that this had been placed on his meal tray card prior to him starting as the DM at the facility and that he didn ' t realize he had a physician ' s order for only 8 oz. of fluids with each meal.	F 309		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (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 record review, observations and staff interviews the facility failed to clean dirty fingernails for 1 of 7 residents reviewed for Activities of Daily Living and failed to provide showers as scheduled for 2 of 7 residents reviewed for Activities of Daily Living (Resident #24 & Resident #33). Findings included:	F 312	Resident #24 (Resident #27 per Stage 2 Sample List) no longer resides in the facility. Resident #33 had a shower on 7/17/17. Consistent assignments were implemented on 8/1/17 to ensure continuity of care and completion of ADL□s. Showers will be documented on shower sheets 2 times per week. The shower sheets will be kept by the hall	8/18/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 312	Continued From page 32 1a. Resident #24 was admitted on 2/18/10 with the current diagnoses of dysphagia, malnutrition, muscle weakness, and dementia. Resident #24 had a care plan in place last updated 5/7/17 for staff assistance with all Activities of Daily Living (ADL's) and required extensive assistance with ADL's. Interventions included for a bath/shower be given as scheduled and nail care and shampoo as needed. The resident's quarterly Minimum Data Set dated 5/20/17 revealed that the resident was severely cognitively impaired and had short term and long term memory impairment. The resident required extensive assistance with bed mobility, locomotion, dressing, eating, and total care with personal hygiene and toilet use and total care with bathing. The resident was always incontinent of bowel and of bladder. The resident was on a mechanical soft diet and received feeding tubes. Nursing notes were reviewed from 7/3/17 and revealed there was no documentation of refusal of care. Review of the ADL flow sheet for July, 2017 revealed that the resident received "bathing" on 7/1//17, 7/2/17, 7/4/17, 7/7/17, 7/11/17, 7/12/17, 7/13/17, 7/14/17, 7/15/17, 7/16/17 and 7/18/17. The flow sheet did not indicate what kind of bathing was given. Review of the shower schedule sheets revealed that the resident was scheduled to have 2 showers a week on Tuesdays and Fridays. The shower sheets indicated that on 7/11/17, 7/14/17, 7/18/17 that the resident was not given a shower and nail care and shaving was not completed.	F 312	nurse and signed by the nurse after each shower, nail care and shave is complete. Nail care will be provided during showers 2 times per week and as needed. In the event that a shower or nail care is not completed the hall nurse will be notified by the nurse aide so that the nurse can document the reason the shower and nail care was not completed. The Unit Manager will make daily rounds for 4 weeks, weekly rounds for 4 weeks to ensure that the hall nurse and the nurse aides are providing Activity of Daily Living (ADL'□s) and that the shower sheets are complete. The issues identified will be reported to the Patient at Risk team meeting weekly by the Director of Nurses and taken to the Quality Assurance committee monthly for 3 months for continued quality improvement.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 312	Continued From page 33	F 312		

Review of the shower sheets revealed that the resident was scheduled for a shower on 7/18/17 but got a shower on 7/19/17 and that nail care/shaving and shower was completed by NA #3. There were no shower sheets for the entire month of 6/2017.
The resident was observed on 7/19/17 at 9:53 AM during morning care. The resident received a bed bath with the assistance from Nursing Assistant #1 and Nursing Assistant #2. The resident was given a bed bath and the resident's clothes were changed.

Nursing Assistant #2 was interviewed on 7/19/17 at 10:45 AM. She stated that staffing was rough mainly on the weekends. She stated that they are usually scheduled for 4 NA but that sometimes 1 person would call out and that left them with 3 NA on the day shift for the whole nursing home. She stated many times it was really hard to get everything done for the resident. She stated that in the mornings she would round, change residents, feed residents and get them up. She stated that she would go back around and complete the small things like clean nails and do oral care but sometimes she just couldn't get to the small things if there wasn't many NAs working. She stated that this resident got showers today on 2nd shift. She was not sure about how this resident got a shower. She stated that they usually give resident's showers according to the schedule but occasionally they have to give a resident a total bed bath if they don't have time.

Nursing Assistant #1 was interviewed on 7/19/17 at 2:57 PM. She stated that resident #24 could be resistance with care and that the resident had scratched her before. She stated that the resident did not refuse care but the resident would grab

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 312	Continued From page 34	F 312		

onto things sometimes. She stated that the resident got showers on second shift but she wasn't sure of the day. She stated that "the floor was pretty heavy" and they have so much to do.

Nurse # 1 was interviewed on 7/19/17 at 3:21 PM. She stated that the resident required total assistance. The resident's showers were scheduled on second shift. The resident would be placed in a shower chair and they would take him for his shower. She stated that she was not make aware of a time that the showers were not completed for this resident. She stated that she knows last week that the resident had a shower. If the resident was not given a shower then he was given a bed bath and the resident was combative at times. She stated that she doesn't think there was enough NA's but they did the best they could. She stated that there were probably some small care areas the NA could not get to but they got to the major things like incontinence care and bathing.

NA #4 (worked second shift) was interviewed on 7/19/17 at 4:18 PM. She stated that the resident required total assistance with ADL's. She stated that sometimes the resident could be resistive to care but had never refused care. She stated that the resident was scheduled for showers on Tuesdays and Fridays. They document electronically for showers, nail care and shaving. They also would try to sign the shower sheet. If a resident refused care multiple times then she would tell the nurse. She has never had to tell the nurse since he's been back from at the hospital that he refused care. She stated that staffing has been hard for the last few months. She stated that many times she can't give all the resident's showers. She stated sometimes they can't get to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 312	Continued From page 35	F 312		

all the showers and she would try to divide the showers up. For example, if 4 residents were scheduled for a shower on Tuesday then she would try to do 2 showers on Tuesday and the other 2 on Wednesday if she wasn't able to get to all of them on Tuesday. She stated but sometimes that when she comes on Wednesday there wouldn't be enough NAs working again and she couldn't always get to the showers as planned the previous day. She stated that other times, resident were just given a bed bath instead of a shower if they couldn't get to them. She stated that she couldn't say if showers were being given regularly for this resident.

The Director of Nursing was interviewed on 7/20/17 at 1:50 PM. She stated that the shower sheets were at the nursing stations and should be documented on if the resident got a shower or full bed bath. They also need to report it to the nurses and they document it electorally under bathing when a resident was given a bath. On the shower days, the staff are supposed to sign on the shower sheets at the nursing station. Resident were supposed to get showers twice a week. Residents were supposed to be getting a bed bath every day if it's not their shower day. She stated that she has told the NA's to "tag team" to get all the showers completed. She stated that sometime when the NA get busy they will forget to sign off the on the shower sheets. She has had up to 1 NA having 5 showers per shift and that when she tells the staff get help from other NA that are working and "tag team". She stated she was not aware of a time when the resident was not getting a shower as scheduled. She stated that she was unable to find any shower sheets for June, 2017. She thought someone may have thrown them out.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 312	Continued From page 36	F 312		

NA #3 was interviewed on 7/21/17 at 4:36 PM. He stated that the resident was given a shower on 7/19/17. He stated that the shower sheet was just overlooked earlier in his shift and when he realized it, he gave the resident a shower on 7/19/17. He stated that he worked 2nd shift. He stated that he would document electronically and on the shower sheets if he remembered. He stated that they just have too many resident to care for to get to everything. He was not sure if the resident got a shower over the weekend or last week but that after he took the resident to the shower, the resident's skin was a shade lighter.

Nursing Assistant #4 (who was assigned to the resident on second shift on 7/4/17) was interviewed on 7/21/17 at 1:59 PM. She stated that she could not remember if she gave this resident a shower on Friday or not.
The administrator was interviewed on 7/21/17 at 11:25 AM. She stated she expected that 2 showers or more to be completed for residents and that there was communication if a shower was missed or refused. Nail care was supposed to be completed as a part of a shower.

1b. Resident's #24 nursing notes were reviewed from 7/3/17 and revealed there was no documentation of refusal of care.

Review of the ADL flow sheet for July, 2017 revealed that the resident received "bathing" on 7/1//17, 7/2/17, 7/4/17, 7/7/17, 7/11/17, 7/12/17, 7/13/17, 7/14/17, 7/15/17, 7/16/17 and 7/18/17. The flow sheet did not indicate what kind of bathing was given.

Review of the shower schedule sheets revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 312	Continued From page 37	F 312		

that the resident was scheduled to have 2 showers a week on Tuesdays and Fridays. The shower sheets indicated that on 7/11/17, 7/14/17, 7/18/17 that the resident was not given a shower and nail care and shaving was not completed. Review of the shower sheets revealed that the resident was scheduled for a shower on 7/18/17 but got a shower on 7/19/17 and that nail care/shaving and shower was completed by NA #3. There were no shower sheets for the entire month of 6/2017.

Resident #24 was observed on 7/19/17 at 9:53 AM during morning care. The resident was given a bath but nail care was not performed. The resident nails were long and had a black substance under them bilaterally. The resident's hands were slightly contracted and the resident had little movement in his left hand.

Nursing Assistant #2 was interviewed on 7/19/17 at 10:45 AM. She stated that staffing was rough mainly on the weekends. She stated that they are usually scheduled for 4 NAs but that sometimes 1 person would call out and that left them with 3 NA on the day shift for the whole nursing home. She stated many times it was really hard to get everything done for the resident. She stated that in the mornings she would round, change residents, feed residents and get them up. She stated that she would go back around and complete the small things like clean nails and do oral care but sometimes she just couldn't get to the small things if there wasn't many NAs working.

Nursing Assistant #1 was interviewed on 7/19/17 at 2:57 PM. She stated that resident #24 could be resistance with care and that the resident had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 312	Continued From page 38	F 312		

scratched her before. She stated that the resident did not refuse care but the resident would grab onto things sometimes. She stated that the resident got showers on second shift but she wasn't sure of the day. She stated they were supposed to do nail care with morning care but that this morning she was nervous and forgot. She stated that "the floor was pretty heavy" and they have so much to do. She wasn't sure the last time that nail care was completed for this resident. She also added that nail care should have been completed this morning. She stated that nail care was an area that may not be completed sometimes because there wasn't enough help and it would be nice if there was another person to round and do things like nail care and oral care on residents. She stated that many days she doesn't get a break because there was so much to do.

Nurse # 1 was interviewed on 7/19/17 at 3:21 PM. She stated that the resident required total assistance. She stated that she doesn't think there was enough NA's but they did the best they could. She stated that there were probably some small care areas the NA could not get to but they got to the major things like incontinence care and bathing.
NA #4 (worked second shift) was interviewed on 7/19/17 at 4:18 PM. Nail care and shaving was supposed to happen as needed and on shower days. They document electronically for showers, nail care and shaving. They also would try to sign the shower sheet. She stated that she did nail care one day last week but did not know the exact date. She started that she didn't cut his nails because the resident was jerking a bit but she did clean them out. If a resident refuses care multiple times then she would tell the nurse. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 312	Continued From page 39	F 312		

has never had to tell the nurse since he's been back from at the hospital that he refused care.

The resident #24 nails were observed on 7/19/17 at 4:00 PM. The resident's nails were still long and had black substance under them bilaterally.

Nursing Assistant #2 was interviewed again on 7/20/17 at 9:54 AM. She stated that the resident #24 nails were dirty and long and that she would try to cut them today. She stated that the nails on the left hand were cleaner than the right hand but both were long.

The Director of Nursing was interviewed on 7/20/17 at 1:50 PM. She stated that when it's the resident's shower day, the resident was supposed to also have nail care completed too.

NA #3 was interviewed on 7/21/17 at 4:36 PM. He stated that resident #24 was given a shower on 7/19/17. He stated that the shower sheet was just overlooked earlier in his shift and when he realized it, he gave the resident a shower on 7/19/17. He stated that he worked 2nd shift. He stated that he didn't even touch the resident's nails on 7/19/17 and told the nurse. He stated that the nurse stated that she would get to it when she could.

The administrator was interviewed on 7/21/17 at 11:25 AM. She stated she expected that 2 showers or more to be completed for residents and that there was communication if a shower was missed or refused. Nail care was supposed to be completed as a part of a shower.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 312	Continued From page 40	F 312		

2. Resident #33 was admitted on 1/22/15 with cumulative diagnoses of dx anoxic brain injury and seizures.

His quarterly Minimum Data Set dated 5/16/17 indicated Resident #33 had severe cognitive impairments with verbal and physical behaviors. He was coded with total assistance for bathing and incontinent of bowel and bladder.

Resident #33 last revised care plan dated 5/23/17 indicated he required extensive to total assistance of two staff members due to his refusal of care, aggression and combativeness at times with his activities of daily living (ADLs). He was care planned for two staff assistance when bathing and reapporach for refusals.

Resident #33 wad on the daily shower sheets as scheduled for showers every Monday and Thursday on first shift.

A review of the daily shower sheets and the electronic Bath Check Roster indicated the following:
June Review:
6/1/17- no documented bath or shower but received a bed bath 6/2/17
6/4/17-shower
6/5/17-bed bath
6/8/17 bed bath
6/9/17 sponge bath
6/12/17-sponge bath
Resident #33 was in the hospital from 6/14/17 until 6/17/17
6/17/17-shower
6/19/17-shower
6/22/17-bed bath

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 312	Continued From page 41 6/26/17-bed bath 6/29/17-shower July Review: Resident #33 was in the hospital from 7/3/17 until 7/6/17 7/10/17-bed bath 7/13/17-shower 7/17/17 shower 7/20/17 bed bath In a telephone interview with Resident #33 ' s responsible party (RP) stated she did not feel he was getting his showers as often as he should. She stated staffing was an ongoing problem and Resident #33 required two staff to shower him. In an interview on 7/19/17 at 4:18 AM, Nursing Assistant (NA) stated staff document in the electronic record their showers. She stated they try to sign the shower sheets when they can but many times it ' s not documented. She stated that staffing has been hard recently and many times they can ' t give all their assigned residents showers. NA #4 stated there were times when a resident was given a bed bath instead of a shower if they staff was unable to get to them to shower them on their shift. In an interview on 7/19/17 at 9:03 AM, NA #6 stated that often the resident was given bed baths instead of showers because there was not enough staff. In an observation on 7/19/17 at 9:50 AM, Resident #33 was self-propelling his wheelchair in the hallway. He appeared clean, absent of odors or incontinence. There was no evidence of behaviors observed.	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 312	Continued From page 42 In an interview on 7/20/17at 8:20 AM, the Director of Nursing (DON) confirmed the facility had two shower chairs and each room had its own shower as well. In a second observation on 7/20/17 at 1:00 PM, Resident #33 was eating lunch in the day room. He appeared absent of odors or evidence of incontinence. He was clean and dressed for weather. When asked if he received a shower today, he responded yes. He was cooperative and absent of verbal or physical behaviors. In an interview on 7/20/17 at 2:20 PM, NA #1 stated she was assigned Resident #33 and she did not have time to give him his shower today. She stated it was not because he was uncooperative today but that she did not have time to complete her assignment or take a lunch break. NA #1 stated she had not reported her inability to complete her assignment to anyone yet but she would report to the second shift aide that she did not get to his shower today. A review of Resident #33 ' s nursing notes from 5/1/17 to present included multiple notes regarding his verbal aggressive and agitation but no documented refusal of his ADLs. In an interview on 7/20/17 at 4:00 PM, the DON stated it was her expectation that Resident #33 receive his showers as scheduled unless he was having active seizure activity. She stated it was also expectation that Resident #33 receive a shower today on second shift.	F 312		
F 315 SS=G	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		8/11/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 315	Continued From page 43 (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff and physician interviews and record review, the facility failed to	F 315	Resident # 20s urinary catheter was changed on 7/19/17.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 315	Continued From page 44 change a urinary catheter as ordered and failed to assess for changes in the appearance of the urinary catheter insertion site (urethra) for 1 (Resident #20) of 1 residents reviewed for urinary catheters. The findings included: Resident #20 was admitted on 11/22/16 with cumulative diagnoses of Parkinson ' s Disease, Cerebrovascular Disease, urinary retention, and history of urinary tract infections. A review of Resident #20 ' s skin assessment on admission dated 11/23/16 read no areas of concern to his urethra. A review of Resident #20 ' s December 2016 physician orders read his urinary catheter was to be changed monthly on the 30th of every month. A review of Resident #20 ' s December 2016 treatment administration (TAR) read his urinary catheter was changed on 12/30/16. A review of Resident #20 ' s January 2017 TAR read his urinary catheter was changed on 01/30/17. A review of Resident #20 ' s February 2017 TAR did not indicate that his catheter was changed at any time during the month. A review of Resident #20 ' s March 2017 TAR did not indicate that his catheter was changed at any time during the month. A nursing note dated 4/3/17 at 2:05 AM read Resident #20 was noted to have hematuria (blood in the urine) and a urine sample was obtained.	F 315	There are no other residents in the facility with urinary catheters. Resident #20□s physician was notified of the change of condition to the resident□s penis on 8/7/17. The Nurse Aides will be in-serviced on urinary catheter care by the Director of Nurses/Regional Nurse Consultant by 8/11/17 to include retracting the foreskin if needed, clean the penis, clean the urethra, and clean the catheter from top to bottom holding and not putting tension on the catheter. Rinse, dry gently and secure catheter with leg strap. Hanging the catheter bag appropriately and notify the charge nurse of any changes. The nurses will be educated by the Director of Nurses/Regional Nurse Consultant by 8/11/17 on documentation of change of condition with notification to physician and responsible party. The 24 hour nursing report will be reviewed daily by the Director of Nurses/Unit Manager for all changes of condition and will be reviewed in daily morning clinical meeting with the administrator for physician and responsible party notification. The Director of Nurses will take all issues and concerns related to physician and responsible party notification to the monthly Quality Assurance Committee monthly for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 315	Continued From page 45	F 315		

A review of PA progress note dated 04/05/17 read Resident #20 was seen for follow up for a fever and increased confusion. The note referenced his chronic indwelling urinary catheter with hematuria and overall declining health. The PA referenced his GU observation of clear yellow urine. There were no documented staff concerns related to Resident #20 ' s urethra or urinary catheter.

A nursing note dated 4/7/17 at 5:28 AM, Resident #20 ' s was leaking. It was changed with Cola colored urine return. He was being treated for a UTI.

A review of Resident #20 April physician orders read his urinary catheter was to be changed monthly of the 17th of each month and his April 2017 TAR read it was changed on 4/17/17.

A review of Resident #20 ' s weekly skin assessment dated 04/24/17 read his had been showered and no skin issues noted. There was no mention of any areas of concern to Resident #20 ' s penis or urethra.

A nursing note dated 5/16/17 at 10:44 PM read Resident #20 was sent to the hospital and admitted with hematuria and a UTI. He returned to the facility on 5/21/17.

A review of Resident #20 ' s hospital records dated 5/21/17 indicated he was admitted with a UTI and hematuria. A review of the admitting physician note indicated Resident #20 was not seen by a urologist because the family opted to seek urological care with another urologist in another town. The note read upon discharge, Resident #20 would need to follow with his personal urologist

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 315	Continued From page 46	F 315		

A review of Resident #20 ' s readmission physician orders dated 5/21/17 read was to be changed the 17th of each month.
A review of his re-admission skin assessment dated 5/21/17 read no areas of concern to his urethra.

A review of a nurse practitioner (NP) note dated 5/26/17 read the visit was for a follow up for a UTI and hospitalization. The note read Resident #20 was seen by urologist in the hospital with no new orders and staff reported a large amount of sediment in his urinary bag. The GU assessment read his urinary catheter was in place with a large amount of sediment. He was currently on an antibiotic for his UTI.

A nursing note dated 6/7/17 at 8:11 AM read his urinary catheter was draining pale yellow milky looking urine with sediment. A note was left for the physician.

A review of a PA progress note dated 6/7/17 read Resident #20 was seen for follow up after his course of antibiotics for a UTI. The note read he had an indwelling urinary catheter and saw urology in the hospital. Staff reported a thick milky looking urine. His GU assessment read he had an indwelling urinary catheter with a large amount of sediment but no blood and the urine was described as yellow. There was no mention of staff concerns related his urethra or penis. The PA left orders for staff to change Resident #20 ' s urinary catheter.

A review of Resident #20 ' s TAR indicated his catheter was changed on 6/8/17.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 315	Continued From page 47	F 315		

A review of Resident #20 significant change Minimum Data Set dated 6/8/17 indicated his Brief Interview for Mental Status (BIMS) of 2 meaning severe cognitive impairment with no behaviors. He was coded for extensive assistance with all his activities of daily living (ADLs) and coded as having a urinary catheter. The Care Area Assessment for his urinary catheter referred reader to his care plan.

A review of Resident #20 ' s care plan dated 6/8/17 read the following problem:

*Resident #20 had a urinary catheter due to urinary retention and prostate cancer. Resident #20 had a history of stretching his tubing in attempts to stand or move about. He needed staff assistance with his catheter care and urinary bag emptying. He had a history of frequent UTI ' s.

Interventions included:
*Observation of Resident #20 ' s skin daily for irritation and redness
*Ongoing assessment of the color and clarity of his urine
*Assessment of Resident for sign of a UTI
*Assistance with his perineal care as needed
*Refer Resident #20 to a Urologist as needed
*Provide catheter care as ordered and as needed
*Change his catheter as ordered
* Obtain Urinalysis and give antibiotics as ordered
*Ensure the catheter tubing is secured to his thigh

A review of Resident #20 ' s June 2017 TAR indicated his urinary catheter was changed on 6/17/17.

A nursing note dated 6/21/17 at 10:13 AM read Resident #20 removed his urinary catheter and it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 315	Continued From page 48	F 315		

was lying at his bedside.

The urinary catheter was replaced without difficulty. There was no documented evidence of trauma of assessment of his urethra.

A review of the urology note dated 6/26/17 read this was the same urologist who referred Resident #20 to his personal Urologist upon his hospital discharge. He agreed to see Resident #20 on 6/26/17 who was accompanied by his responsible party (RP). The urology note said he last saw Resident #20 in November 2016 during a hospitalization. The note read he had a urinary catheter change monthly by the nursing home staff. The Urologist noted on his physical exam that his catheter was draining clear urine. There were no new orders.

A review of Resident #20 ' s July 2017 TAR read his urinary catheter was changed on 7/17/17.

In an observation on 07/17/17 at 9:00 AM, Resident #20 was lying in a low bed with urinary catheter bag attached to the right side of his bed frame resting on the floor.

In an observation on 07/17/17 at 12:10 PM, Resident #20 was lying in a low bed with a sheet partially un-obstructing the view of his right and left thighs. There was no observed catheter securement device to either thigh, the urinary catheter was attached to the right side of the bed frame with the bag resting on the floor. There was no observed blood in the urinary tubing but his urine appeared pale yellow with white sediment.

In an observation on 07/18/17 at 10:21 AM, Resident #20 was lying in a low bed. His catheter

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 315	Continued From page 49	F 315		

bag was attached to the left side of his bed frame resting on the floor. There was observed blood tinged urine in his catheter tubing.

In an observation and interview on 7/18/17 at 10:23 AM, Nursing Assistant (NA) #13 stated she had worked at the facility for 3 months. NA #13 pulled back Resident #20 ' s sheet. There was no observed anchoring device to either thigh. She stated she was not aware that his urinary catheter should be anchored to his thigh. She stated she was instructed to make sure his urinary bag was attached to his bed but not aware that his urinary bag should not be lying on the floor. NA #13 stated in the past when she was assigned Resident #20 she was only instructed to empty his urinary bag. She was not aware of how to perform his urinary catheter care or what to report to the nurse.

In an interview on 07/18/17 at 10:38 AM, Nurse #2 stated Resident #20 was known to pull on his catheter and he rolled from side to side. She stated she had observed blood in in his urine on occasion. Nurse #2 stated the aides clean his catheter and she assessed his catheter daily to ensure there were no concerns. Nurse #2 stated the aides had not told her that his catheter was not anchored and not told her about any observed concerns to his penis or urethra.

In an interview on 07/18/17 at 3:30 PM, Nurse #1 stated she started in January of 2017 and was assigned Resident #20 on 7/17/17 and thought he did not have a leg strap because it irritated his leg. She stated she did not assess his catheter insertion site or penis but expected the aides to report anything unusual to her.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 315	Continued From page 50	F 315		

In an observation on 7/18/17 at 3:40 PM, Resident #20 was lying in a low bed with his urinary catheter bag attached to the right side of his bed frame resting on the floor

In an observation and interview on 07/19/17 at 9:30 AM, NA #2 stated she had worked at the facility for one year and she was assigned Resident #20. During an observation of Resident #20 ' s catheter care, she cleaned around his urethra and cleaning his tubing. She did not attempt to clean the entirety of his penis. NA #2 was asked to further reveal his penis by pushing back his testicles and foreskin. Observed was a penile tear extending from the urethra down the underside of the shaft of his penis measuring approximately 2 inches in length. NA #2 stated his penis was not like that when he was admitted in November 2016.

In an interview on 07/19/17 at 9:50 AM, Nurse #2 confirmed she looked at Resident #20 ' s penis daily. She stated she thought he had a small tear on his admission but it did not look like it did today. Nurse #2 stated his catheter was changed monthly on night shift and the penile tear should have been reported when it was observed during his catheter change.

In an interview on 07/19/17 at 10:50 AM, Nurse #3 stated she worked third shift. She stated she thought Resident #20 had a small tear for "awhile". She described it as a 2 centimeter "ridge" on his penis but she had not observed his penis in probably a month. She stated the other nurse who worked nights usually changed his urinary catheter. She confirmed Resident #20 ' s catheter was documented changed by the other night nurse on 7/17/17 on third shift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 315	Continued From page 51	F 315		

In a telephone interview on 07/19/17 at 3:10 PM, Nurse #6 confirmed she worked nights and worked third shift on 7/17/17. She stated she had changed Resident #20 ' s urinary catheter in the past but not recently. Nurse #6 was reminded she documented on his TAR she changed his urinary catheter Monday night on 07/17/17. Nurse #6 stated she did not change his catheter on 07/17/17 as documented. She was unable to offer an explanation as to why she initialed off on the TAR that she changed Resident #20 ' s urinary catheter when on interview, she stated she did not. She stated she thought she changed his urinary catheter a month or so ago and had observed pus and blood at his urethra but had not noted the penile tear. Nurse #6 stated Resident #20 pulled at his catheter and scratched himself to the genital area. She stated she was not aware he if he was to have a catheter securement device.

A review of the facility incident logs on 7/16/17 at 4:00 PM from November 2016 to present included no intakes regarding any injury or change in Resident #20 ' s catheter insertion site at his urethra.

In an interview on 7/19/17 at 4:20 PM, NA #14 stated it was her first day back on the 200-hall assignment after a 3-month rotation on another hall. The Director of Nursing (DON) and NA #14 were observed assessing Resident #20 ' s penis. The DON pulled back Resident #20 ' s foreskin and testicles to reveal the penile tear. NA #14 stated "it wasn ' t like that 3 months ago". NA #14 stated he may have had some bleeding and maybe a little split but not like what it looks like now. The DON stated she was unable to recall if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 315	Continued From page 52	F 315		

it had worsened since she last observed it a "few weeks ago".

There were no nursing notes again until 7/19/17 at 4:59 PM which read Resident #20 ' s urinary catheter was changed without difficulty.

A nursing note dated 7/20/17 at 8:15 AM read Resident #20 ' s urinary catheter tubing was secured in place with a leg strap.

In a telephone interview on 7/20/17 at 11:45 AM, the Urologist who saw Resident #20 on 6/26/17 stated due to the request of Resident #20 ' s RP, he did not see him in the hospital. The RP wanted him to go another urologist who was not near the facility. He stated he agreed to see Resident #20 on 06/26/17. The Urologist stated during the visit, he did not assess Resident #20 ' s penis, urethra and was not aware of a penile tear. He stated some penile erosion was expected from long term urinary catheter however a 2-inch tear would have been the result of trauma or the staff not ensuring the use of a leg strap to prevent the weight of the urinary bag tugging on his catheter.

In a telephone interview on 07/21/17 at 9:45 AM, Resident #20 ' s physician stated it was her expectation that Resident #20 ' s urinary catheter be secured to prevent tension, changed as ordered and needed. She also stated it was her expectation that his catheter and insertion site be assessed daily and she be notified of any changes such as trauma or tearing to his penis or urethra.

In an interview on 07/21/ at 10:40 AM, the Administrator stated her expectations were the same as Resident #20 ' s physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 323 SS=J	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations, Physician and staff interviews, and records review the facility failed to prevent an avoidable fall from mechanical lift resulting in injury for 1 of 6 residents reviewed for accidents and falls [Resident # 47]. On 4/19/17 Resident # 47 who was severely cognitively impaired had a fall with injuries while being weighed by mechanical lift, with only one person assist. The assigned staff after weighing	F 323	Resident #47 no longer resides in the facility. Other residents affected were re-assessed on 7/18/17 for the need for the Hoyer/mechanical lift and the care plans and care guides were updated to indicate 2 person assist and transfer by the Rehab Director.	8/18/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 323	Continued From page 54 Resident # 47 had unhooked only three (3) loops not all four (4) from mechanical lift resulting in a fall with injuries. Resident # 47 had a laceration to her head, fracture to the first cervical vertebra (C1 Jefferson fracture) and fracture to the second cervical vertebra (Type 2 odontoid fracture) due to the fall. Immediate Jeopardy began on 4/19/17 when the sling's four straps were not all unhooked before the sling was removed from the resident. This caused the resident to be pulled into the floor. The immediate jeopardy was removed on 7/21/17 when the facility's acceptable credible allegation of compliance was verified. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to allow the facility time to implement a full plan of corrections. Findings included: During an observation on 7/18/17 at 3:17 PM and reviewing the manual of the mechanical lift, the lift has the capability to record weights. Sling diagram in the manual indicates the sling has 4 loop straps. Two (2) loop straps on the top and 2 loop straps to the bottoms with 3 adjustments. The 2 loop straps in the top together are referred as 1T - 1st loop (smallest) or 2T - 2st loop (middle) or 3T- 3rd loop (longest). Similarly the 2 loop straps in the bottom of the sling are referred to as 1B - 1st loop (smallest) or 2B - 2st loop (middle) or 3B- 3rd loop (longest). Manual also indicates to attach the loops nearest the patient shoulder, to the handle bar hooks of the lift nearest each shoulder using the same length and color of loop strap at each side. The sling leg	F 323	The involved staff was counseled on 4/20/17 by the administrator for not utilizing 2 staff members when using the Hoyer/mechanical lift while weighing a resident and re-inserviced on use of the Hoyer/mechanical lift by the Rehab Director, with return demonstration of using a Hoyer/mechanical lift on 4/20/17. On 4/20/17 and 4/21/17 the Nurse Aides were trained to include full time and part time staff by the therapy department on the proper use of 2 people when using the mechanical lifting devices with return demonstration of skill. The training will continue with all new hire□s and annually to show continued competence by the therapy department. The continued need for the mechanical lift will be assessed on admission per the lift assessment by the Director of Nurse's and/or Rehab Director and will be reviewed quarterly with the scheduled MDS and as needed by the unit manager. On 7/18/17 the direct care staff to include full time and part time staff was re-educated by the administrator/Director of Nurse's on the importance of reviewing the care guide daily for updates and to understand the expected outcome of the resident care. Care guides are located on the inside of each closet door. Incidents will be brought to the daily clinical meeting by the Director of Nurse's and a follow up review will be completed in the interdisciplinary weekly PAR	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 323	Continued From page 55	F 323		

lying over the left leg is crossed over and to the hook of the hanger bar located on the right side. The similar procedure followed for the right leg. For rigid patients the loops go straight up along the outside of the leg and hooked on the longest loop. Manual indicates to remove the sling after lowering, when the patient's weight is supported by the bed continue to lower the lift to release the tension of the loop, detach the sling from the lift and move the lift away from the patient.

Resident was admitted to the facility on 7/25/12, with documented diagnosis of Non Alzheimer's Dementia, history of falls, Dysphagia, osteoporosis, lack of coordination, and abnormalities with gait and poly osteoarthritis.

Review of Physician orders from 4/1/17 through 4/20/17 revealed resident was not on any pain medication.

Review of the Quarterly Minimum Data Set (MDS) dated 4/10/17 revealed admission date 5/7/14. Resident coded as minimum hearing, unclear speech and rarely /never make self-understood. Resident was severely cognitively impaired. Resident was coded as total dependent and needing two person assist with bed mobility, transfer and bathing, and having functional limitation impairment for both sides of lower extremity. MDS indicated resident was not on any pain medication.

Review of the care plan dated 4/18/17 revealed identification of problem areas 1) requiring total assist with Activities of Daily living (ADL), 2) Potential for injury from fall due to poor trunk control . The goals indicated minimize potential for significant decline in ADL status and minimize

(Patient at Risk) meeting. Findings will be reported by the Director of Nurse's monthly on an ongoing basis at the monthly QA Committee.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 323	Continued From page 56	F 323		

potential for injury from fall. The interventions indicate resident a two assist transfer with the total lift. Geri sleeves to bilateral arms as orders and resident to wear orthotic and hip abduction braces as ordered with routine skin checks. Utilize pillows and positioning devices as indicated for assistance with resident's poor truck control. Monitor resident for safety issues/ needs and report to appropriate personnel to prevent falls.

Review of Nursing Notes dated 4/19/17 revealed resident was been weighed by Nurse Aide #9 (NA), when putting resident on bed, NA undid only 3 loops not all 4 from lift. When the lift was moved Resident# 47 was pulled to the floor and bumped her head to her roommate's bed rail. Resident was sent to Emergency Room (ER) for treatment and evaluation. Nurse Practitioner and responsible party were notified.

Review of the incident report dated 4/19/17 read in part - NA was weighing resident when putting the resident on bed undid 3 loops not all 4 from the lift. When NA moved the lift, resident was pulled to floor and bumped head on roommate's bed rail. Resident has laceration to top of head due to amount of blood could not assess wound properly. Pressure applied to the wound on the head.

Physician Order dated 4/19/17 at 2:14 PM read in part- sent out to Emergency Department (ED) for evaluation post fall.

Review of Emergency Medical Services (EMS) report 4/19/17 at 2:28 PM read in part: Patient on floor lying supine. Nurse reported resident was being transferred from wheelchair to bed, fell and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 323	Continued From page 57	F 323		

hit head. Neck pain on palpation due to fall from bed 3 feet (ft.). Neck pain on palpation and tender spine and paraspine. Immobilized to hospital.
Review of ER report dated 4/19/17 at 3: 05 PM read in part: Patient in ER, lift broke and patient fell, sustained a laceration on top of scalp. Diagnosis: posterior displacement of second cervical vertebra (type 2 odontoid fracture) and non-displaced fracture of first cervical vertebra, and possible compression of upper cervical cord.

Hospital admission note dated 4/19/17 at 10:18 PM read in part - Resident was admitted to Medical Center. Hospital admission note indicate that resident was transferred from Hospital via EMS with a first cervical vertebra (C1) Fracture. Patient was sent to hospital from her nursing home after sustaining a fall from a mechanical lift. Unknown if there was loss of consciousness (LOC). She fell from a height of 3 to 5 ft. and point of impact was the head and neck. Patient makes only incomprehensible sounds and was unable to follow command. Per EMS was her normal mental status. She has a laceration to the top of her head. Point of impact head and neck.

Review of ED Provider note dated 4/19/17 at 10:46 PM read in part- accident occurred 6- 12 hours ago. Fall occurred at Skilled Nursing Facility (SNF) from Mechanical lift. She fell from a height of 3 to 5 ft. and point of impact head and neck. Clinical impression - Closed displaced fracture of first cervical vertebra, unspecified fracture morphology.

Review of Orthopedic Note dated 4/19/17 at 10:48 PM read in part: patient was seen at an outside hospital where she was found to have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 323	Continued From page 58	F 323		

first cervical vertebra fracture and second cervical vertebra fracture. Assessment and Recommendation indicated C1 Jefferson fracture and C2 type 2 odontoid fracture. Maintain Miami J (MJ) cervical collar at all times; head of bed (HOB) as tolerated; this injury does not have risk of neurologic compromise, however risk associated with surgical interventions have high morbidity. Recommend no acute orthopedic surgical intervention.

Review of Employee Counseling / Discipline Statement dated 4/20/17 revealed NA #9 failed to utilize two staff for use of Mechanical lift for weighing a resident. Corrective actions were 1) in-service on Mechanical lift. 2) Return demonstration of use of Mechanical lift.

Review of the Medical Discharge Summary dated 4/21/17 read in part- Resident blood pressure (BP) remained elevated despite home regime. Hemodynamically stable at discharge and at baseline mental status. Recommended maintain MJ collar at all times.

Review of nursing note dated 4/21/17 read in part: Resident arrived to facility via facility transport at 7:17 PM, MJ collar in place on the neck. Resident stable, alert, nonverbal. Vital signs taken. Resident skin dry and intact with some bruising noted to back of both hands and right lower arm at IV site, respiration even and unlabored . Incontinent of Bowel and Bladder, no acute distress noted, will continue to monitor.

Review of Physician orders dated 4/21/17 revealed Lisinopril 30 milligrams (MG) tablet 1 orally (PO) daily for hypertension. Acetaminophen 325 MG tablet take 2 tablets PO every 6 hours for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 323	Continued From page 59	F 323		

7 days. Amlodipine Besylate 10 MG take 1 tablet PO daily for hypertension. Roxicodone 5 MG Tablets take 1 tablet PO 6 hours as needed (PRN). Maintain MJ collar at all times.

Reviews of Physician notes dated 4/25/17 read in part - Follow up after hospital observation stay due to fall from Mechanical lift. Resident diagnosed with a scalp laceration, C1 Jefferson fracture and type 2 odontoid fracture at the hospital. Orthopedic recommendation: conservative treatment with an MJ collar due to risk of high morbidity with surgery due to baseline function and co-morbidities. Resident can move all extremities, fingers and toes. Resident's BP was elevated from baseline, possibility due to pain and amlodipine has started. Vital Signs stable since return.

Review of post incident action report dated 4/26/17 revealed staff re-educated on use of lift. IDT review for fall with Social worker, administrator, activity director, therapy and MD.

Review of Medication Administration Record (MAR) for April and May 2017 revealed:

4/1/17 through 4/20/17 - resident did not receive any pain medication.

4/21/17 through 4/25/17 - resident received acetaminophen 325 MG 2 tablet Twice a Day (BID) every 6 hours for pain.

4/25/17 through 4/30/17 -Resident was administered scheduled Norco 5-325 tablet one tablet BID for pain. Resident did not receive any as needed (PRN) Norco 5-325 tablet one tablet BID for pain.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 323	Continued From page 60	F 323		

5/1/17 through 5/12/17- resident received scheduled Norco 5-325 tablet one tablet BID for pain. Resident did not receive any PRN Norco 5-325 tablet one tablet BID for pain.

5/1/17 through 5/13/17 - Resident was assessed for pain at 6:00 AM, 2:00 PM, 10:00 PM. Pain indicated. Resident was checked for maintaining MJ collar at all times.

Review of Certificate of Death dated 5/13/17 read in part- expired in the facility, Probable aspiration due to dysphagia due to Alzheimer's dementia.

During an interview with Nurse #2 on 7/18/17 at 7:05 AM, nurse indicated NA #9 was assigned residents weights the day of the incident. Nurse stated NA #9 came running to her and informed her about Resident #47 fall, unsure of time (may be before or after lunch). Nurse #2 stated when she entered Resident #47's room, resident was lying against her roommate's bed frame and there was lot of blood. Nurse #2 stated she was unsure if the resident had hit the floor or the bed frame. She indicated she did not move the resident due to blood loss and asked the NA #9 to call the supervisor while she was applying pressure to the head. Nurse #2 further stated supervisor had called EMS. Resident #47 was examined by EMS upon arrival and transported her to the hospital in a stretcher. Nurse #2 further stated that two (2) people were required when using the mechanical lift and was unsure why NA #9 was working alone with the mechanical lift. Nurse #2 also stated prior to the fall resident had poor neck control and would always turn to the right side. She indicated Resident #47 base line was resident was alert and not oriented and was a total assist with her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 323	Continued From page 61	F 323		

ADL's. Nurse #2 further stated that after the fall resident had a decline in her medical condition, was not eating well, but able to consume some fluids. She stated that the resident had a MJ collar placed in the hospital and this was also hindering the resident comfort.

During an interview with NA #8 on 7/18/17 at 9:41 AM, NA stated there was one resident that had a fall because there was only one NA that used the lift. NA #8 stated that there were 4 NA on duty that day but NA #9 did not ask for help with the lift and used the lift with only one person. She stated the resident hit her head and ended up going to the hospital.

During an interview with Nurse #4 on 7/18/17 at 10:28 AM, Nurse stated she was called to the room by a NA (did not remember the name). Nurse #4 stated that NA had thought all the clips were unhooked and was startled by the roommate's family entered the room, that is when she moved the lift, the resident was pulled out with the lift as one clip was left unhooked. Nurse #4 indicated she had assessed the resident. She stated Resident #47 head was bleeding, resident was alert and talking, laying on her right side in between the beds. She stated Resident #47 was assessed by EMS and transported the resident to the hospital.

During an interview with the Nurse Practitioner (NP) on 7/18/17 at 11:31 AM, NP indicated resident was total dependent, did not move a lot, advanced and progressing dementia, no verbal cues of pain or no verbal response, DNR and on comfort care. NP stated that resident was declining prior to the fall and was on limited interventions for comfort care. NP indicated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 323	Continued From page 62	F 323		

on the day of the fall, she was notified and resident was sent to the hospital for evaluation. NP indicated that after resident returned from the hospital, resident was made comfortable with pain medication, not overly sedated. She stated Resident # 47 was consuming less and appetite had decreased. NP indicated she was not present at the time of death, and death was a natural death due to deteriorating conditions.

During an interview with the NA #9 on 7/18/17 at 11:38 AM, NA indicated she was usually assigned weights for the residents. She stated on the day of the incident, she was using a mechanical lift to weigh Resident # 47. NA #9 explained the resident was placed on the pad and hooked, lifted up to be weighed and when the weight was taken the resident was put down on the bed. She stated at this time the resident's roommate family member walked in. NA #9 stated she had removed 3 of the 4 clips and when the family member walked in, she got distracted. NA #9 stated she responded "patient care" and after he left, NA stated she thought she had removed all of the 4 hooks from the pad and moved back. NA #9 stated at this point she felt a tug and she could not reach the resident as resident was fallen down. She stated she immediately called the nurse for assessments. She stated she was working alone with the mechanical lift that day. She indicated facility had other NA, but she just did not ask for assistance. She also stated she usually works alone with mechanical lift for weights as she was assigned to that duty for a long time. She indicated that she only asks for help if the resident was combative or a heavy weight person.

During an interview with Director of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 323	Continued From page 63	F 323		

(DON) on 7/20/17 at 12:15 PM, DON indicated she was in the facility at the time of the fall however not witness it. She indicated NA #9 came running and reported to the nurse about the fall. DON stated when she entered the room, Resident #47's head was lying against the roommate's bed frame. She stated she was unsure why NA #9 was distracted and why NA #9 was working alone with the lift without any assistance. DON stated all the lifts in the facility were 2 person assist.

During an interview with the Physician (MD) on 7/20/17 at 3:38 PM via phone, MD indicated he was working as the Medical Director for the facility during the time frame of the incident. MD stated on the day of the incidence his NP called him and asked him if she could give orders for resident to be transferred to the hospital. MD indicated he was made aware of the incidence from his NP, Acting DON and previous Administrator. He stated it was not appropriate for the resident to be transferred by one person if the care plan indicated 2 person assist for transfer.

During an interview with the administrator on 07/21/2017 at 10:41 AM, Administrator indicated the staff should follow the care plan and by not using 2 person for mechanical lift it was a neglect. She further stated that staff did not think she was transferring Resident #47 as she was weighing the resident.

Review of the Quality Assurance (QA) Process revealed on 4/19/17 at 2:15PM, Resident #47 was positioned in the mechanical lift over the bed and approximately 6 inches above the mattress for the purpose of obtaining weights. After getting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 323	Continued From page 64	F 323		

the resident weights, NA placed the resident on the mattress and started unhooking the 4 clips that held the pad onto the lift. After unhooking 3 of the 4 hooks, the resident's roommate family member came into the room. NA had shouted "resident care" and they left the room. NA turned and back to the resident she was caring for and at this point started to pull the mechanical lift back to the bed. NA had forgotten she had not unclipped the 4th clip and the resident started to roll and fall from the bed. NA was not able to move fast enough around the mechanical lift to reach or catch the resident from falling. NA got help to assess the resident. Resident #47 was assessed by the nurse and resident had a laceration on the top of her head from hitting her head on her roommate side rails. Physician and responsible party were notified.

The QA Process further indicated the NA was reeducated on the use of the mechanical lift with return demonstration to validate skills. All NA's were reeducated on the use of the mechanical Lift and sit to stand with return demonstration to validate skills. All new NA hired will be validated for competency of Mechanical lift and Sit to stand during their orientation period. Random observation will be completed to ensure 2 staff present during use of Mechanical and sit to stand lift, observations will be ongoing to ensure continued quality improvement.

QA process did not indicate the facility had identified all the residents that used the mechanical lifts or updated the care guide for the residents using the lift. No monitoring methods were in place.

On 7/18/17 at 2:30 AM the administrator,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 323	Continued From page 65	F 323		

corporate nurse consultant, corporate vice president were informed of immediate jeopardy. The Administrator provided an acceptable credible allegation of compliance on 7/21/17.

Credible allegation of Compliance: F 323

On 4/19/17 at 2:15 PM the resident was positioned in the Hoyer lift over her bed at approximately 6 inches above the mattress for the purpose of obtaining her weight. After getting the residents weight the c.n.a. returned the resident to the mattress and started unhooking the 4 hooks that held the pad onto the lift. After unhooking 3 of the 4 hooks a visitor entered the room and the c.n.a. stated out "resident care" and the visitor left the room. The c.n.a. turned back to the resident she was weighing and at this point started to pull the mechanical back from the bed. The c.n.a. had forgotten that she had not undone the fourth hook and the resident had started to roll and fell from the bed. The c.n.a. was distracted by the visitor coming into the room causing her not to undo the fourth hook. The c.n.a. did not have a second person to assist with the mechanical lift because she stated she was not transferring the resident and this was her common practice for obtaining weight for this resident.

The conclusion of the root cause, if following the policy the c.n.a. would have had a second staff while using the mechanical lift per the policy of the facility. The second staff member could have told the first c.n.a. that the fourth hook was still attached prior to moving the mechanical lift and could have prevented the fall.

On 4/19/17 at 2:15 PM while obtaining the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 323	Continued From page 66	F 323		

residents weight the employee pulled the Hoyer lift without unhooking all 4 hooks causing the resident to fall from the bed hitting her head and obtained a laceration on the top of her head.

The physician and family was notified on 4/19/17 at 2:30 PM and the resident was sent to the emergency room for evaluation and admitted for observation and returned to the facility on 4/21/17 with a diagnosis of C1 fracture . The resident expired on 5/13/17.

The involved staff was counseled on 4/20/17 by the administrator for not utilizing 2 staff members when using the Hoyer lift while weighing a resident and re-inserviced on use of the Hoyer lift by the Rehab Director, with return demonstration of using a Hoyer lift on 4/20/17.

On 4/20/17 and 4/21/17 the Certified Nursing Assistants were trained by the therapy department on the proper use of 2 people when using the mechanical lifting devices with return demonstration of skill. The training will continue with new hire's and annually to show continued competence. All fulltime certified nursing assistant were trained by the therapy department on 4/20/17 and 4/21/17, there are 2 per diem staff that have not had the training and will not be allowed to work until training is completed.

Other residents affected were re-assessed on 7/18/17 for the need for the Hoyer lift and the care plans and care guides were updated to indicate 2 person assist and transfer by the Rehab Director.

Since the training on 4/20/17 and 4/21/17 there have been no other residents affected by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 323	Continued From page 67	F 323		

deficient practice. On 4/19/17 around the time of the incident the incident log was reviewed and there were no other incidents involving improper use of mechanical lifts.

The continued need for the mechanical lift will be reviewed quarterly with the scheduled MDS and as needed by the unit manager.

On 7/18/17 the direct care staff was re-educated on the importance of reviewing the care guide daily for updates and to understand the expected outcome of the residents care. Care guides are located on the inside of each closet door.

QIO was contacted 7/19/17 for assistance with a full plan of correction to achieve and maintain compliance. A QAPI self-assessment was completed today and a visit has not been scheduled at this time. The self-assessment was sent to the facility by the QIO and the assessment was completed on-line. After the QIO reviews they will call the facility and schedule a visit.

The validation of the credible allegation was completed on 7/21/17 at 12:30 PM by doing the following:

1a. On 7/18/17 at 3:17 PM observed use Mechanical lift to assist a resident transferred from wheel chair to bed. 3 NA were assisting with transfer. One NA operated the mechanical lift while the other 2 assisted with transfer by holding the resident. All loops were unclipped before the mechanical lift was moved. Resident was safely transferred and no issues were noted.

1 b. On 7/18/17 at 3:22 PM observed use Mechanical lift for weighing a resident laying in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 323	Continued From page 68	F 323		

her bed. One NA operated the lift while the other NA supported and reassured the resident. Resident was safely weighed. No issues were noted.

2. Review of In-service Education report revealed on 4/20/17 and 4/21/17 the facility's direct staff were trained on 2 person assist for the mechanical lift and the sit to stand lift to include 2 person assist for weights; Training included return demonstration. Eighteen (18) NA's were identified on the in- service education sheet. The in-service with return demonstration was completed by the Occupational Therapist. Skills Competency Checklists were completed for the 18 NA's on proper use of gait belt, use of mechanical lifts, and use of sit to stand transfer equipment.

During an interview with DON on 7/20/17 at 12:15 PM, DON stated all direct care staff were re-trained by Physical Therapist (PT) on how to properly use mechanical lifts. She stated the NA's had to demonstrate their understanding skills.

3. Review of Employee Counseling / Discipline Statement dated 4/20/17 revealed NA #9 was counseled on 4/20/17 related to failing to utilize 2 staff for use of mechanical lift for weighing a resident. Corrective Actions were 1) Employee was in-serviced on mechanical lift. 2) Return demonstration of use of mechanical lift.

4. On 7/21/17 the care plan and Care guides of other residents identified for the need for mechanical lift were reviewed. The care plans were updated to indicate sit to stand lift with 2 staff assist or transfers using total lift with 2 assist. Care Guides were updated to indicate sit to stand lift with 2 staff assist or transfers using

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 323	Continued From page 69 total lift with 2 assist. 5. Interview with multiple direct staff on 7/21/17 revealed staff were educated by administrator on 7/18/17 about reviewing the care guide daily and to understand the expected outcome of the residents care. Direct care staff were able to locate the residents care guide inside of the resident closet door. 6. During an interview with the Administrator on 7/21/17 at 11:21 AM, Administrator indicated that facility has identify those resident that use the lift. She further stated DON and MDS coordinator will implement the care guide and monitor staff follow the care guide that were placed in the resident's closets. She also stated that rehab director was going to review the need to the lift quarterly with the MDS coordinator and as needed to keep the assessment and care guides current. 7. Reviewed QAPI self-assessment tool. QIO notified on 7/19/17 at 2:30 PM. Facility waiting for visit to be scheduled. During an interview with the Administrator and Vice President/Director of Operations on 07/21/2017 at 11:56 AM, they indicated that a discussion was held to discuss the significance of Immediate Jeopardy and the expedited protection of other residents with the potential to be affected by the same deficient practice. The immediate jeopardy was removed on 7/21/17 when the facility's acceptable credible allegation of compliance were verified. The facility will remain out of compliance at a lesser scope and severity.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 325	Continued From page 70	F 325		
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (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- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a nutritional assessment and implement nutritional interventions for a resident with weight loss (Resident #67) for 1 of 5 residents that were reviewed for nutritional status. Findings Included: Resident #67 was admitted to the facility on 6/9/17 and diagnoses included fracture of the left femur, iron deficiency anemia and Alzheimer ' s disease. A care plan for Resident #67 with an initiation date of 6/9/17 revealed potential for weight loss related to leaving 25% or more of food uneaten at	F 325	Resident #67□s nutritional assessment was completed 7/19/17 by the Dietary Manager. The Registered Dietician (RD) reviewed Resident #67□s record on 8/3/17 indicating a weight gain to 141.3 pounds, which is an increase, prior weight loss noted, overall eating well. May see weight fluctuations with diagnosis of Alzheimer□s Dementia. OK with current body weight, continue diet, and monitor weight trends, honor preferences. For any residents identified having weight loss the RD will make recommendations for either supplements, extra portions or	8/18/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 325	Continued From page 71 most meals. Interventions included for the Dietitian to evaluate current resident nutritional status. An admission minimum data set (MDS) dated 6/21/17 for Resident #67 revealed she required limited, one person assist with eating, had not experienced significant weight loss and had impaired cognition. A review of the medical record revealed the weights for Resident #67 were as follows: 6/9/17 - 146.5 pounds (lbs), 6/21/17 - 141.3 lbs and 6/28/17 - 135.8 lbs. This reflected a weight loss of 10.7 lbs / 7.3% in 19 days. A review of the medical record for Resident #67 revealed an entry on 6/15/17 that was titled "PAR" note and stated admission weight 146.5, weekly weights per protocol. A review of the medical record for Resident #67 revealed an entry on 6/22/17 that was titled "PAR" note and stated meeting with Administrator, Unit Manager, MDS, Therapist and Activities for wound. Weight was 141.3 lbs, her weight was down. She gets a multivitamin, surgical incision is healing, continue plan of care. A review of the medical record for Resident #67 revealed an entry on 6/29/17 that was titled "PAR" note. Reviewed for weights and post fall. Weight was 135.8 lbs showing a weight loss of 5.5 lbs over 7 days. Weight loss related to acute episode. She is on multivitamin supplement. Diet is regular. Will continue to monitor weights. A review of the physician orders for June 2017 for Resident #67 revealed she was on a regular diet and did not have any nutritional supplements	F 325	appetite stimulants in writing to the attending physician, Director of Nurse's, Dietary Manager and Administrator. The RD documents the recommendations and the reason for the recommendations in the residents chart for physicians to review. The interdisciplinary Patient at Risk (PAR) team reviewed Resident #67□s weight on 8/3/17 indicating a weight gain of .2 pounds over 7 days and slight weight gain over 30 days. Receives a Regular diet. Continue plan of care. All residents identified with nutritional assessments, weight loss and interventions recommended by the RD will be reviewed weekly in PAR meeting and changes made accordingly. All other residents identified with no nutritional assessment in the past 90 days will have a nutritional assessment completed by 8/18/17 by the Dietary Manager (DM) and/or RD. The RD and the DM were in serviced on 8/10/17 on completing the nutritional assessment for admissions, annually, significant changes and as needed. The nutrition assessment will be completed according to the assessment reference date (ARD) to ensure timely completion. The MDS coordinator will post a list of all assessments due on a weekly basis. The MDS coordinator will report to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 325	Continued From page 72 ordered. A review of the dietary tray card, provided by the Dietary Manger (DM), for Resident #67 revealed she was on a regular diet. There were no food / beverage preferences, supplements or fortified food items identified on the tray card. . An interview on 7/19/17 at 11:03 am with the DM revealed he had just started completing the nutritional documentation for residents 2 to 3 weeks ago. He stated prior to that he believed the Registered Dietitian (RD) and the MDS nurse were completing the nutritional assessments for residents. He explained new admissions to the facility should be visited within 72 hours of admission to obtain their food preferences and a nutritional assessment should be completed by the ARD (assessment reference date for the MDS) date. The DM added new admissions should be weighted weekly and residents with a 2 pound loss in a week would be considered a significant weight loss and should be re-assessed for nutritional interventions. He stated he was not sure what the RD ' s schedule was but believed he came 3 times per month. The DM stated he was not sure why there was no nutritional assessment completed for Resident #67 when she was admitted. He stated he would have expected the RD to have completed a nutritional assessment when she was admitted and to have re-assessed her for nutritional interventions when she started losing weight. An interview on 7/19/17 at 12:00 pm with the MDS Nurse revealed she and the inter-disciplinary team would provide the RD with the names of the residents they were reviewing in PAR meetings. She stated she would also provide	F 325	administrator of any nutritional assessment not completed timely. All issues of nutritional assessments not completed timely will be taken to the monthly QA committee meeting by the administrator monthly for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 325	Continued From page 73 a report of the new admissions to the RD if requested. The MDS nurse explained Resident #67 had been reviewed in the PAR meetings, but they had not added any additional supplements or calorie source when she had lost weight. She stated they thought Resident #67 ' s weight loss may have been related to her recent surgery and placement in the skilled side of the facility. The MDS nurse reported she did not see that a nutritional assessment had been completed for Resident #67. She stated she would have expected that a nutritional assessment was completed when she was admitted. A telephone interview on 7/19/17 at 2:08 pm was conducted with the RD. He stated he had been the RD consultant for the facility for about a year and a half and was originally contracted to come one day a month. He added the facility had experienced turnover with the DM position and sometimes he had come to the facility twice a month. He stated the last date he was in the facility was 6/13/17 and he did not have Resident #67 on his list to review. The RD further stated her name must have been missed somehow. He explained it was his expectation a nutritional assessment would have been completed on admission and a nutritional intervention would have been added when she began losing weight. An interview on 7/21/17 at 11:01 pm with the Administrator revealed it was her expectation that a nutritional assessment would be completed for all new admissions. She additionally stated she expected residents with weight loss would be assessed by the RD.	F 325		
F 332 SS=D	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	F 332		8/18/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 332	Continued From page 74 (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff and pharmacist interviews and record review, the facility failed to maintain a medication error rate of less than 5% by failure to follow pharmacy recommendation by crushing an extended release medication and by not administering the correct dosage ordered of a medication. There were 2 errors of 25 opportunities resulting in an 8% error rate. This was evident for 1 of (Resident #14) 6 residents observed during the medication pass. The findings included: 1. Resident #14 had a physician order dated 12/13/16 for Toprol XL 25 milligrams (mg) by mouth daily for uncontrolled hypertension. The electronic medication administration record and the pharmacy medication label read "DO NOT CRUSH." On 07/19/17 at 9:20 AM, Nurse #6 was observed during a medication pass. She was observed crushing Resident #14 ' s Toprol XL along with her other ordered medications. She administrated Resident #14 her medications by mixing them in pudding. In an interview on 7/19/17 at 9:30 AM, Nurse #6 stated she mistakenly crushed Resident #14 ' s Toprol XL because she did not observe the warning on the electronic MAR or on the medication punch card.	F 332	Resident #14 currently receives Toprol XL 25 milligrams (mg) by mouth daily *DO NOT CRUSH and Vitamin D3 1,000 units 3 tablets by mouth every day as ordered by physician. Nurse #6 had a medication administration skills validation observation completed on 8/9/17. The Director of Nurses/Unit Manager/Regional Nurse Consultant will complete medication administration skills validation for licensed nurses and medication aide□s to ensure the understanding of medication administration according to physician□s orders and pharmacy medication labels. The skills validation will be completed by 8/18/17. The Director of Nurses/Unit Manager Nurse Consultant will continue to complete 4 skills validations monthly for 3 months. Results of medication administration skills validation will be reported to the monthly Quality Assurance committee by the Director of Nurses for any issues identified for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 332	Continued From page 75 The consultant pharmacist was interviewed on 7/19/17 at 5:50PM and stated by crushing Resident #14 ' s extended release Toprol, the resident could have experienced a sudden drop in her blood pressure. In an interview on 7/20/17 at 4:00 PM, the Director of Nursing (DON) stated her expectation that Resident #14 dose of Toprol XL should have have been administered whole and not crushed. 2. Resident #14 had a physician order dated 7/12/17 for Vitamin D3 1,000 units by mouth daily. On 07/19/17 at 9:20 AM, Nurse #6 was observed during a medication pass. She was observed administrating a Vitamin D3 400-unit tablet from a pharmacy punch card. She crushed Resident #14 medications, mixed them in pudding and administrated the incorrect dose to Resident #14. In an interview on 7/19/17 at 9:30 AM, Nurse #6 stated the physician must have written an order increasing her dose of Vitamin D3 and she should have pulled the correct dose from house stock. In an interview on 7/20/17 at 4:00 PM, the DON stated her expectation that Resident #14 received the correct dose of Vitamin D3 as ordered.	F 332		
F 353 SS=D	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to	F 353		8/18/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 353	Continued From page 76	F 353		

provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).
[As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)]

(a) Sufficient Staff.
(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

(i) Except when waived under paragraph (e) of this section, licensed nurses; and

(ii) Other nursing personnel, including but not limited to nurse aides.

(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

(a)(4) Providing care includes but is not limited to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 353	Continued From page 77 assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to provide sufficient nursing staff to provide Activities of Daily Living (ADLs) including the provision of showers and nail care for 2 of 7 dependent residents reviewed for ADLs (Resident #24 and Resident #33). The findings included: 1. Resident #24 was admitted on 2/18/10 with the current diagnoses of malnutrition, muscle weakness, and dementia. Resident #24 had a care plan in place last updated 5/7/17 for staff assistance with all Activities of Daily Living (ADL's) and required extensive assistance with ADL's. Interventions included for a bath/shower be given as scheduled and nail care and shampoo as needed. The resident's quarterly Minimum Data Set dated 5/20/17 revealed that the resident was severely cognitively impaired and had short term and long term memory impairment. The resident required extensive assistance with bed mobility, locomotion, dressing, eating, and total care with personal hygiene and toilet use and total care with bathing. The resident was always incontinent of bowel and of bladder. The resident was on a mechanical soft diet and received feeding tubes. Nursing notes were reviewed from 7/3/17 and revealed there was no documentation of refusal of care.	F 353	Resident #24 (Resident #27 per Stage 2 Sample List) no longer resides in the facility. Resident #33 had a shower on 7/17/17. Consistent assignments were implemented by the Administrator and Director of Nurses on 8/1/17 to ensure continuity of care and completion of Activity of Daily Living (ADL□'s). Showers will be documented on shower sheets 2 times per week. The shower sheets will be kept by the hall nurse and signed by the nurse after each shower, nail care and shave is complete. Nail care will be provided by the assigned nurse aide during showers 2 times per week and as needed. In the event that a shower or nail care is not completed the hall nurse will be notified by the nurse aide so that the nurse can document the reason the shower and nail care was not completed. A new hire orientation was completed on 8/1/17 by Human Resources and consisted of 7 new nursing staff. 1 Registered Nurse (RN), 1 Licensed Practical Nurse (LPN), 1 Medication Aide (MA), 4 Nurse Aides (NA) and 2 Nurse Aides returned from Family Medical Leave.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 353	Continued From page 78 Review of the ADL flow sheet for July, 2017 revealed that the resident received "bathing" on 7/1/17, 7/2/17, 7/4/17, 7/7/17, 7/11/17, 7/12/17, 7/13/17, 7/14/17, 7/15/17, 7/16/17 and 7/18/17. The flow sheet did not indicate what kind of bathing was given. Review of the shower schedule sheets revealed that the resident was scheduled to have 2 showers a week on Tuesdays and Fridays. The shower sheets indicated that on 7/11/17, 7/14/17, 7/18/17 that the resident was not given a shower and nail care and shaving was not completed. Review of the shower sheets revealed that the resident was scheduled for a shower on 7/18/17 but got a shower on 7/19/17 and that nail care/shaving and shower was completed by NA #3. There were no shower sheets for the entire month of 6/2017. The resident was observed on 7/19/17 at 9:53 AM during morning care. The resident received a bed bath with the assistance from Nursing Assistant #1 and Nursing Assistant #2. The resident's clothes were changed, but nail care was not performed. The resident's finger nails were long and had a black substance under them bilaterally. The resident's hands were slightly contracted and the resident had little movement in his left hand. Resident #24 finger nails were observed on 7/19/17 at 4:00 PM. The resident's nails were still long and had black substance under them bilaterally. Nursing Assistant (NA) #2 was interviewed on 7/19/17 at 10:45 AM. She stated that staffing was rough mainly on the weekends. She stated that	F 353	A staffing meeting is conducted daily to include the Administrator, Director of Nurses and the staff coordinator. The staffing is reviewed daily by the staff coordinator for the staffing needs for each shift and adjusted accordingly for the next scheduled day. Any nursing staff call outs will be reported to the Director of Nurses and/or staff coordinator to assist for any staffing needs. The Unit Manager will make daily rounds for 4 weeks, weekly rounds for 4 weeks to ensure that the hall nurse and the nurse aides are providing ADL□s and that the shower sheets are complete. The issues identified will be reported to the Patient at Risk team meeting weekly by the Director of Nurses and taken to the Quality Assurance committee monthly for 3 months for continued quality improvement.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 353	Continued From page 79	F 353		

they are usually scheduled for 4 NAs but that sometimes 1 person would call out and that left them with 3 NAs on the day shift for the whole nursing home. She stated many times it was really hard to get everything done for the resident. She stated that in the mornings she would round, change residents, feed residents and get them up. She stated that she would go back around and complete the small things like clean nails and do oral care but sometimes she just couldn't get to the small things if there wasn't many NAs working. She stated that this resident got showers today on 2nd shift. She was not sure about how this resident got a shower. She stated that they usually give resident's showers according to the schedule but occasionally they have to give a resident a total bed bath if they don't have time.

Nursing Assistant #1 was interviewed on 7/19/17 at 2:57 PM. She stated that Resident #24 could be resistance with care and that the resident had scratched her before. She stated that the resident did not refuse care but the resident would grab onto things sometimes. She stated that the resident got showers on second shift but she wasn't sure of the day. She stated they were supposed to do nail care with morning care but that this morning she was nervous and forgot. She stated that "the floor was pretty heavy" and they have so much to do. She wasn't sure the last time that nail care was completed for this resident. She also added that nail care should have been completed this morning. She stated that nail care was an area that may not be completed sometimes because there wasn't enough help and it would be nice if there was another person to round and do things like nail care and oral care on residents. She stated that many days she doesn't get a break because there

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 353	Continued From page 80	F 353		

was so much to do.

Nurse # 1 was interviewed on 7/19/17 at 3:21 PM. She stated that Resident #24 required total assistance. The resident's showers were scheduled on second shift. The resident would be placed in a shower chair and they would take him for his shower. She stated that she was not made aware of a time that the showers were not completed for this resident. She stated that she knows last week that the resident had a shower. If the resident was not given a shower then he was given a bed bath and the resident was combative at times. She stated that she doesn't think there was enough NA's but they did the best they could. She stated that there were probably some small care areas the NA could not get to but they got to the major things like incontinence care and bathing.

The staff scheduler was interviewed on 7/19/17 at 3:34 PM. She stated that there has been a challenge with keeping staff and getting staff to work at the facility. They are staffed based on how many residents are in the building. They try to staff 3 to 4 NA on third, 4 to 5 on second shift and 5 to 6 on first shift. They do have call outs and they don't have enough staff to cover when people have days off. They are in the process of hiring and waiting to do orientation and are waiting on background checks. If there was a call out then she would try to call to replace the staff and if it's really short with only 3 or 4 NA's working the entire facility then she will go upstairs to work on 1st shift. Nurses on second shift and third shift would also call NA's to come in. If no one would come in, then they would just work with 2 NA's. If there is just 1 NA for the entire facility. They would call an NA to come work from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 353	Continued From page 81	F 353		

the assisted living. Third shift has been having about 2 to 3 NAs and second shift has been having about 3 to 4 NAs per shift. She stated that she hasn't had to work in the last month. She stated that they have had agency nurses since last week that just started. The staffing has just been rough the last month. She stated that many days she doesn't think there is enough NA and that they can't get to all the care sometime but it's just the little things like oral care or nail care. She stated that the NAs would come to her and ask her if she could get others to come in but she stated she was doing all she could to get staff to come in but just can't get them to come in sometimes.

NA #4 (worked second shift) was interviewed on 7/19/17 at 4:18 PM. She stated that Resident #24 required total assistance with ADL's. She stated that sometimes the resident could be resistive to care but had never refused care. She stated that the resident was scheduled for showers on Tuesdays and Fridays. She stated that she did nail care one day last week but did not know the exact date. She started that she didn't cut his nails because the resident was jerking a bit but she did clean them out. They document electronically for showers, nail care and shaving. They also would try to sign the shower sheet. If a resident refused care multiple times then she would tell the nurse. She has never had to tell the nurse since he's been back from at the hospital that he refused care. She stated that staffing has been hard for the last few months. She stated that many times she can't give all the resident's showers. She stated sometimes they can't get to all the showers and she would try to divide the showers up. For example, if 4 residents were scheduled for a shower on Tuesday then she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 353	Continued From page 82	F 353		

would try to do 2 showers on Tuesday and the other 2 on Wednesday if she wasn't able to get to all of them on Tuesday. She stated but sometimes that when she comes on Wednesday there wouldn't be enough NAs working again and she couldn't always get to the showers as planned the previous day. She stated that other times, resident were just given a bed bath instead of a shower if they couldn't get to them. She stated that she couldn't say if showers were being given regularly for this resident.

Nursing Assistant #2 was interviewed again on 7/20/17 at 9:54 AM. She stated that Resident #24's nails were dirty and long and that she would try to cut them today. She stated that the nails on the left hand were cleaner than the right hand but both were long.

The Director of Nursing (DON) was interviewed on 7/20/17 at 1:50 PM. She stated that the shower sheets were at the nursing stations and should be documented on if the resident got a shower or full bed bath. They also need to report it to the nurses and they document it electorally under bathing when a resident was given a bath. On the shower days, the staff were supposed to sign on the shower sheets at the nursing station. Residents were supposed to get showers twice a week and when it's the resident's shower day, the residents were supposed to also have nail care completed too. Residents were supposed to be getting a bed bath every day if it's not their shower day. She stated that she has told the NA's to "tag team" to get all the showers completed. She stated that sometime when the NA get busy they will forget to sign off the on the shower sheets. She has had up to 1 NA having 5 showers per shift and that when she tells the staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 353	Continued From page 83	F 353		

get help from other NA that are working and "tag team". She stated she was not aware of a time when the resident was not getting a shower as scheduled. She stated that she was unable to find any shower sheets for June, 2017. She thought someone may have thrown them out. The DON stated that they are having many call outs. On 3rd shift, they want 4 NAs working at night. They are trying to hire staff now. They are not supposed to be absent within the first 90 day of being hired. She stated that she worked the medication cart on Tuesday from 3:30 PM to 5:30 PM. She stated that this was unusual. She stated that she would like to have 5-6 NAs on second shift and she stated that she and the staffing scheduler would start calling NAs to come in. If others couldn't come in then they had to just work with what they have. She stated that scheduler would be pulled to the floor. She stated that they have had their ups and downs with staff as does every building and staffing 2nd shift is a challenge with any building. She stated that they are doing the best they could with staffing and they have some good NAs.

NA #3 was interviewed on 7/21/17 at 4:36 PM. He stated that the resident was given a shower on 7/19/17. He stated that the shower sheet was just overlooked earlier in his shift and when he realized it, he gave the resident a shower on 7/19/17. He stated that he didn't even touch the resident's nails on 7/19/17 and told the nurse. He stated that the nurse stated that she would get to it when she could. Stated that they just have too many resident to care for to get to everything.

Nursing Assistant #4 was interviewed on 7/21/17 at 1:59 PM. She stated that she could not remember if she gave this resident a shower on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 353	Continued From page 84	F 353		

Friday (7/14/17) or not.

The administrator was interviewed on 7/21/17 at 11:25 AM. She stated she expected that 2 showers or more to be completed for residents and that there was communication if a shower was missed or refused. Nail care was supposed to be completed as a part of a shower. She stated that she wanted 6 NAs on 1st shift and 5 NAs on 2nd shift. When there was only 2 NAs for the entire facility, the nurses would make round with the NAs. She stated that one night she came in at 2:00 AM and the facility was quiet, there was no odor noted and there was 3 NAs, a nurse and a med aide working. She stated that the scheduler would get coverage if needed and sometimes 1st shift will stay over until someone comes in. She does not feel that patients have been affective by the staffing. She stated she has replaced a few NAs since she has been here. They are in the process of hiring one more NA for third shift right now. She added that she and the DON were responsible with the hiring and interviews for new staff.

2. Resident #33 was admitted on 1/22/15 with cumulative diagnoses of anoxic brain injury and seizures.
His quarterly Minimum Data Set dated 5/16/17 indicated Resident #33 had severe cognitive impairments with verbal and physical behaviors. He was coded with total assistance for bathing and incontinent of bowel and bladder.

Resident #33 last revised care plan dated 5/23/17 indicated he required extensive to total assistance of two staff members due to his refusal of care, aggression and combativeness at times with his activities of daily living (ADLs). He

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 353	Continued From page 85	F 353		

was care planned for two staff assistance when bathing and approached for refusals.

Resident #33 was on the daily shower sheets as scheduled for showers every Monday and Thursday on first shift.
A review of the daily shower sheets and the electronic Bath Check Roster for the months of June 2017 and July 2017 indicated the following for Resident #33:

June 2017 Review:
6/1/17 (Thursday) - no documented bath or shower but received a bed bath 6/2/17
6/4/17 (Sunday)-shower
6/5/17 (Monday)-bed bath
6/8/17 (Thursday) - bed bath
6/9/17 (Friday) - sponge bath
6/12/17 (Monday) - sponge bath
Resident #33 was in the hospital from 6/14/17 until 6/17/17
6/17/17 (Saturday) - shower
6/19/17 (Monday) - shower
6/22/17 (Thursday) -bed bath
6/26/17 (Monday) -bed bath
6/29/17 (Thursday)-shower

July 2017 Review:

Resident #33 was in the hospital from 7/3/17 until 7/6/17
7/10/17 (Monday) - bed bath
7/13/17 (Thursday) - shower
7/17/17 (Monday) - shower
7/20/17 (Thursday) - bed bath

In a telephone interview with Resident #33's responsible party (RP) stated she did not feel he was getting his showers as often as he should.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 353	Continued From page 86	F 353		

She stated staffing was an ongoing problem and Resident #33 required two staff to shower him. The staff scheduler was interviewed on 7/19/17 at 3:34 PM. She stated that there has been a challenge with keeping staff and getting staff to work at the facility. They are staffed based on how many residents are in the building. They try to staff 3 to 4 NA on third, 4 to 5 on second shift and 5 to 6 on first shift. They do have call outs and they don't have enough staff to cover when people have days off. They are in the process of hiring and waiting to do orientation and are waiting on background checks. If there was a call out then she would try to call to replace the staff and if it's really short with only 3 or 4 NA's working the entire facility then she will go upstairs to work on 1st shift. Nurses on second shift and third shift would also call NA's to come in. If no one would come in, then they would just work with 2 NA's. If there is just 1 NA for the entire facility. They would call an NA to come work from the assisted living. Third shift has been having about 2 to 3 NAs and second shift has been having about 3 to 4 NAs per shift. She stated that she hasn't had to work in the last month. She stated that they have had agency nurses since last week that just started. The staffing has just been rough the last month. She stated that many days she doesn't think there is enough NA and that they can't get to all the care sometime but it's just the little things like oral care or nail care. She stated that the NAs would come to her and ask her if she could get others to come in but she stated she was doing all she could to get staff to come in but just can't get them to come in sometimes.

In an interview on 7/19/17 at 4:18 AM, Nursing Assistant (NA) #4 Stated staff document in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 353	Continued From page 87	F 353		

electronic record their showers. She stated they try to sign the shower sheets when they can but many times it's not documented. She stated that staffing has been hard recently and many times they can't give all their assigned residents showers as scheduled. NA #4 stated there were times when a resident was given a bed bath instead of a shower if they staff was unable to get to them to shower them on their shift.

In an interview on 7/19/17 at 9:03 AM, NA #6 stated that often the resident was given bed baths instead of showers because there was not enough staff.

In an observation on 7/19/17 at 9:50 AM, Resident #33 was self-propelling his wheelchair in the hallway. He appeared clean, absent of odors or incontinence. There was no evidence of behaviors observed.
In a second observation on 7/20/17 at 1:00 PM, Resident #33 was eating lunch in the day room. He appeared absent of odors or evidence of incontinence. He was clean and dressed for weather. He was cooperative and absent of verbal or physical behaviors.

In an interview with NA#1 on 7/20/17 at 2:20 PM, she stated she was assigned Resident #33 and she did not have time to give him his shower today. She stated it was not because he was uncooperative today but that she did not have time to complete her assignment or take a lunch break. NA #1 stated she had not reported her inability to complete her assignment to anyone yet but she would report to the second shift aide that she did not get to Resident #33's shower today.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 353	Continued From page 88 A review of Resident #33's nursing notes from 5/1/17 to present included multiple notes regarding his verbal aggressive and agitation but no documented refusal of his ADLs. In an interview on 7/20/17 at 4:00 PM, the Director of Nursing (DON) stated it was her expectation that Resident #33 receive his showers as scheduled unless he was having active seizure activity. She stated it was also expectation that Resident #33 receive a shower today on second shift.	F 353		
F 490 SS=J	483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff, Nurse Practitioner and Physician interviews, the facility administration failed to provide the leadership and management necessary to ensure resident's needs were met for 1 of 6 residents reviewed for accidents (Resident #47). On 4/19/17 Resident # 47 who was severely cognitively impaired had a fall with injuries while being weighed by mechanical lift, with only one person assist. The assigned staff after weighing Resident # 47 had unhooked only three (3) loops not all four (4) from mechanical lift resulting in a fall with injuries. Resident # 47 had a laceration to her head, fracture to the first cervical vertebra	F 490	On 7/17/17 a department manager meeting was held by the Director of Clinical Operations and re-inserviced the Administrator and Department Managers on the Abuse/Neglect policy. On 7/18/17 the Director of Operations initiated 100% retraining for all Nurse Aides regarding the policy for the use of the mechanical lift requiring 2 staff to operate. Resident #47 no longer resides in the facility.	8/18/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 490	Continued From page 89 (C1 Jefferson fracture) and fracture to the second cervical vertebra (Type 2 odontoid fracture) due to the fall. Resident # 47 expired on 5/13/17 Immediate Jeopardy began on 4/19/17 when the sling's four straps were not all unhooked before the sling was removed from the resident. This caused the resident to be pulled onto the floor. The immediate jeopardy was removed on 7/21/17 at 12:30 PM when the facility's acceptable credible allegation of compliance was verified. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to allow the facility time for to implement full plan of corrections. Findings included: This tag is cross referred to: 1. F323 - Based on observations, Physician and staff interviews, and records review the facility failed to prevent an avoidable fall from mechanical lift resulting in injury for 1 of 6 residents reviewed for accidents and falls [Resident # 47]. 2. F224 - Based on observations, interview with facility staff, physician and Administrator and records review the facility failed to prevent an avoidable fall from mechanical lift resulting in injury for 1 of 6 residents reviewed for accidents and falls [Resident # 47]. On 7/18/17 at 2:30 AM the administrator, corporate nurse consultant, corporate vice president were informed of immediate jeopardy. The Administrator provided an acceptable	F 490	Other residents with the potential to be affected were re-assessed on 7/18/17 for the need for the mechanical lift and the care plans and care guides were updated to indicate 2 person assist/transfer by the Rehab Director. The continued need for the mechanical lift will be assessed on admission per the lift assessment by the Director of Nurse's and/or Rehab Director and will be reviewed quarterly with the scheduled MDS and as needed by the unit manager. On 7/18/17 the direct care staff was re-educated by the administrator/Director of Nurse's on the importance of reviewing the care guide daily for updates and to understand the expected outcome of the resident care. Care guides are located on the inside of each closet door. Incidents will be brought to the daily clinical meeting by the Director of Nurse's, a follow up review will be completed in the interdisciplinary weekly PAR (Patient at Risk) meeting. Findings will be reported by the Director of Nurse's monthly on an ongoing basis at the monthly QA Committee. On 7/19/17 the Quality Improvement Organization (QIO) was contacted for assistance to achieve and maintain compliance. A QIO visit was conducted on 7/31/17 to include the QIO Quality Advisor, Administrator, DON and MDS coordinator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 490	Continued From page 90 credible allegation of compliance on 7/21/17. Allegation of Compliance: F 490 On 4/19/17 at 2:15 PM the resident was positioned in the Hoyer lift over her bed at approximately 6 inches above the mattress for the purpose of obtaining her weight. After getting the residents weight the c.n.a. returned the resident to the mattress and started unhooking the 4 hooks that held the pad onto the lift. After unhooking 3 of the 4 hooks a visitor entered the room and the c.n.a. stated out "resident care" and the visitor left the room. The c.n.a. turned back to the resident she was weighing and at this point started to pull the mechanical lift back from the bed. The c.n.a. had forgotten that she had not undone the fourth hook and the resident had started to roll and fell from the bed. The c.n.a. was distracted by the visitor coming into the room causing her not to undo the fourth hook. The c.n.a. did not have a second person to assist with the mechanical lift because she stated she was not transferring the resident and this was her common practice for obtaining weight for this resident. The conclusion of the root cause, if following the policy the c.n.a. would have had a second staff while using the mechanical lift per the policy of the facility. The second staff member could have told the first c.n.a. that the fourth hook was still attached prior to moving the mechanical lift and could have prevented the fall. On 4/19/17 at 2:15 PM while obtaining the residents weight the employee pulled the Hoyer lift without unhooking all 4 hooks causing the resident to fall from the bed hitting her head and	F 490	All other residents as having the potential to be affected by the use of the mechanical lift had their transfer status re-assessed by the DON and MDS coordinator on 7/18/17 for the need for the mechanical lift. Care plans and care guides were updated by the MDS coordinator to indicate 2 person assist and transfer for those requiring the mechanical lift. On 4/20/17 and 4/21/17 the nurse aides to include full time and part time staff were re-educated on the use of the mechanical lift and skills observations completed by the Rehab Director. The nurse aides will be trained by the therapy department on the use of the lifting device upon hire and annually to show continued competency on the lifting device. The direct care staff to include full time and part time staff was re-educated by the administrator on 7/18/17 on the importance of reviewing the care guide daily for updates and to understand the expected outcome of the residents care. Staff were not permitted to work until the in-service was completed. Care guides for each resident are located on the inside of their closet door. Upon hire the direct care staff will be educated by the Director of Nurses and/or Unit Manager on care guides, its purpose	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 490	Continued From page 91 obtained a laceration on the top of her head. The physician and family was notified on 4/19/17 at 2:30 PM and the resident was sent to the emergency room for evaluation and admitted for observation and returned to the facility on 4/21/17 with a diagnosis of C1 fracture. The resident expired due to respiratory complications on 5/13/17. On 4/20/17 and 4/21/17 the Certified Nursing Assistants were trained by the therapy department on the proper use of 2 people when using the mechanical lifting devices with return demonstration of skill. The training will continue with new hire's and annually to show continued competence. All full-time certified nursing assistants were trained by the therapy department on 4/20/17 and 4/21/17, there are 2 per diem staff that have not had the training and will not be allowed to work until training is completed. During the end-of-day meeting with department managers on the afternoon of 07/17/17 the Director of Clinical Operations re-inserviced the Administrator and Department Managers on the corporation's Abuse and Neglect policy. On 7/18/17 the Director of Operations and the Director of Clinical Operations met with the Administrator to review the significance of an immediate jeopardy situation and the expedited protection of the facility residents. The Director of Operations and the Director of Clinical Operations will continue to monitor the facility's adherence to corporate policies and regulated guidelines with daily conference calls and weekly on-site visits. On 7/18/17 the Director of Operations initiated 100% retraining for all Magnolia Estates C.N.A.'s	F 490	and their location. On 7/19/17 in-services began for all staff in all departments and they were re-educated on the facility□s abuse/neglect policy by the administrator and Director of Nurse's and the education included to follow the care plan and care guide for each individual resident and was completed on 7/24/17. Staff were not permitted to work until the in-services were complete. A 24 hour initial report was completed by the administrator and sent to North Carolina Division of Health and Human Service/Health Care Personnel Investigation on 7/20/17. A 5 day report was completed 7/26/17 and sent to North Carolina Division of Health and Human Service/Health Care Personnel Investigation by the administrator (HCPI). The HCPI has a scheduled visit for 8/9/17 for their investigation. Upon any reports of abuse/neglect the administrator/Director of Nurse's will report any allegations to HCPI within the 2 hour/24 hour time frame. Any reportable allegations will be reviewed by the V.P. of Operations/Regional Nurse Consultant and in addition the reports will be reviewed in monthly Quality Assurance (QA) Committee for 3 months and the quarterly Executive QA Committee for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 490	Continued From page 92 regarding the policy for the use of the mechanical lift requiring 2 staff to operate and use the lift correctly. Other residents with the potential to be affected by this deficient practice were re-assessed on 7/18/17 for the need for the mechanical lift and the care plans and care guides were updated to indicate 2 person assist and transfer by the Rehab Director. The continued need for the mechanical lift will be reviewed quarterly with the scheduled MDS and as needed. On 7/18/17 the direct care staff was re-educated by the Administrator on the importance of reviewing the care guide daily for updates and to understand the expected outcome of the residents care. Care guides are located on the inside of each closet door. On 07/20/17, the Director of Operations inserviced the Administrator regarding the fact that they are the on-site person responsible for planning, organizing, implementing, evaluating, and directing the facility's programs and activities in accordance with the corporation's established policies. Several methods used to accomplish this are Quality Assurance and Performance Improvement committees involving the Medical Director, Social Worker, DON, Pharmacist, Medical Records Director, Dietary Manager and Housekeeping Supervisor to identify issues related to quality assessment and assurance activities as needed and developing and implementing appropriate plans of action for identified facility concerns. In addition, quarterly Satisfaction Surveys are sent to Responsible	F 490	continued quality improvement.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 490	Continued From page 93	F 490		

Parties and Residents, the results of which are presented to QA and modifications made to policies and procedures as required. The Administrator has an open door policy which allows all residents, visitors, and staff members to voice concerns at any time.

The charge nurse will monitor the C.N.A.s to ensure that the care guides are followed. Any deviation from the care provided according to the care guides will be reported to the DON to be investigated for possible neglect. As part of the corporation's progressive disciplinary process, employees violating corporate policy and/or regulatory guidelines will be counseled up to and including discharge by the appropriate Department Manager and Administrator.

QIO was contacted 7/19/17 for assistance with a full plan of correction to achieve and maintain compliance. A QAPI self-assessment was completed on 07/19/17 and returned to the QIO assigned to the facility. After reviewing the self-assessment, the QIO indicated they would call the facility to schedule their first visit.

Verification of Credible Allegations: F490

1. When were you last in-serviced on the Abuse/ Neglect Policy? What is the facility policy on related to neglect?

During an interview with Nurse #3 on 7/21/17 at 9:00 AM, Nurse # 3 stated she was in serviced on abuse/neglect yesterday. She also stated she would report neglect to DON and Administrator.

During an interview with NA #15 on 7/21/17 at 9:05 AM, NA stated she underwent abuse and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 490	Continued From page 94	F 490		

neglect training yesterday. She stated she would report it and indicated she knew when to report it and the steps to take when she sees neglect.

During an interview with NA #2 on 7/21/17 at 9:19 AM, NA stated She was trained this week on Abuse and Neglect. She stated that she would report to the nurse and knew all steps that she would take.

During an interview with Nurse #5 on 7/21/17 at 9:31 AM, she stated she was in-service yesterday on Abuse and Neglect. She further stated that Neglect was when someone doesn't provide care for the resident.

During an interview with NA #16 on 7/21/17 at 9:39 AM, NA indicated that she was trained in Abuse and Neglect. She stated, if she saw a resident being abused, she would not leave the resident and would notify the nurse.

During an interview with MDS coordinator on 7/21/17 at 11:15 AM, MDS Coordinator stated she was in serviced this past week on abuse/neglect. She stated Neglect was one of the 5 forms of abuse. She further stated Neglect would be not doing something that was on the care plan and leaving resident unattended.

During an interview with certified occupational therapist assistant (COTA) on 7/21/17 at 11:52 AM, COTA stated she was trained on abuse and neglect 7/20/17. She stated the policy was to report abuse/neglect. She stated that Neglect was care not provided to a resident who needs it.

2. How will you monitor the facility's adherence with Policies and Regulations?

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 490	Continued From page 95 During an interview with Vice president / Director of Operations on 07/21/2017 at 11:56 AM, he stated that he and corporate nurse will monitor facility's adherence with daily conference call one of them will be in building at least weekly. 3. When were you last trained on the policy of using mechanical lifts? How many staff are required to use the lift? During an interview with Nurse #3 on 7/12/17 at 9:00 AM, Nurse # 3 stated that 2 people were required to use the lift. She also stated that she will monitor staff by going into the resident's room and checking for 2 people using the lift. During an interview with NA #15 on 7/ 21/17 at 9:05 AM, NA stated 2 people are needed when using the lift. She stated she was in serviced when she first hired and once since then. She further stated that she was also educated on care guide and care plan. She stated that the resident's care guide were located in the resident's closet. During an interviewed with NA #2 on 7/21/17 at 9:19 AM. She stated that she underwent training about the lift a few weeks ago on how to properly use the lift and that 2 people are required when using a lift. She also indicated care guide were in resident's closets for every resident. During an interview with NA #1 on 7/21/17 at 9:32 AM. She stated that it takes to use 2 people to use the lift. She stated that care guides were inside the closet on how to provide care for residents.	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 490	Continued From page 96	F 490		

During an interview with NA #16 on 7/21/17 at 9:39 AM, NA indicated that they have to have 2 peoples to use the lift no matter what and was educated on this. She further stated care guide on the resident closet doors indicated how to provide care for residents.

During an interview with NA #5 on 7/ 21/17 at 9:40 AM, NA stated she was in serviced early in the week. She further stated that she was also educated on care guide and care plan.

4. How will you monitor NA's that the care guides are being followed: What if there is a deviation from the care guide. What do you do?

During an interview with Nurse #3 on 7/12/17 at 9:00 AM, Nurse #3 stated she would communicate any changes to the care guide to the NA. She further stated that if NA did not follow the care guide, she would counsel the aide.

During an interview with Nurse #5 on 7/21/17 at 9:31 AM, she stated she would checks shower sheets, and do observation of care. She stated that she would counsel the NA if they have missed a care or not providing care.

5. Are Care plans and Care guides for residents with lifts updated?

On 7/21/17 the care plan and care guides of other residents identified for the need for mechanical lift were reviewed. The care plans were updated to indicate sit to stand lift with 2 staff assist or transfers using total lift with 2 assist. Care Guides were updated to indicate sit to stand lift with 2 staff assist or transfers using total lift with 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 490	Continued From page 97 assist. 6. Reviewed QAPI self-assessment tool. QIO notified on 7/19/17 at 2:30 PM. Facility waiting for visit to be scheduled. During an interview with the Administrator and Vice President/Director of Operations on 07/21/2017 at 11:56 AM, they indicated that a discussion was held to discuss the significance of Immediate Jeopardy and the expedited protection of other residents with the potential to be affected by the same deficient practice. The immediate jeopardy was removed on 7/21/17 when the facility's acceptable credible allegation of compliance were verified. The facility will remain out of compliance at a lesser scope and severity.	F 490		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain-	F 514		8/18/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 514	Continued From page 98 (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed ensure the accuracy of a treatment administration record (TAR) indicating a urinary catheter change was provided when it not done as ordered for 1 (Resident #20) of 1 residents reviewed for urinary catheters. The findings included: Resident #20 was admitted on 11/22/16 with cumulative diagnoses of Parkinson ' s Disease, Cerebrovascular Disease, urinary retention, and history of urinary tract infections. A review of Resident #20 ' s readmission physician orders dated 5/21/17 read was to be changed the 17th of each month. A review of Resident #20 significant change Minimum Data Set dated 6/8/17 indicated his Brief Interview for Mental Status (BIMS) of 2 meaning severe cognitive impairment with no	F 514	Resident #20 had his urinary catheter changed on 7/19/17, it was documented in the nurse□s notes accordingly. There are no other residents in the facility with urinary catheters. An in-service will be completed by 8/18/17 by the Director of Nurses/Regional Nurse Consultant on accurate and complete documentation for Nurse #6. All other nurses/medication aides will be in-serviced by the Director of Nurses/Regional Nurse Consultant on accurate and complete documentation by 8/18/17. Nurse□s documentation will be reviewed on American Health Tech (AHT) by the Director of Nurses/Unit Manager on a daily basis. Any inaccuracy□s in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 514	Continued From page 99 behaviors. He was coded for extensive assistance with all his activities of daily living (ADLs) and coded as having a urinary catheter. The Care Area Assessment for his urinary catheter referred reader to his care plan. A review of Resident #20 ' s care plan dated 6/8/17 read the following problem: *Resident #20 had a urinary catheter due to urinary retention and prostate cancer. Resident #20 had a history of stretching his tubing in attempts to stand or move about. He needed staff assistance with his catheter care and urinary bag emptying. He had a history of frequent UTI ' s. Interventions included: *Change his catheter as ordered A review of Resident #20 ' s June 2017 TAR indicated his urinary catheter was changed on 6/17/17. A review of Resident #20 ' s July 2017 TAR read his urinary catheter was changed on 7/17/17. In an observation and interview on 07/19/17 at 9:30 AM, NA #2 stated she had worked at the facility for one year and she was assigned Resident #20. During an observation of Resident #20 ' s catheter care, she cleaned around his urethra and cleaning his tubing. She did not attempt to clean the entirety of his penis. NA #2 was asked to further reveal his penis by pushing back his testicles and foreskin. Observed was a penile tear extending from the urethra down the underside of the shaft of his penis measuring approximately 2 inches in length. NA #2 stated his penis was not like that when he was admitted in November 2016.	F 514	documentation identified will be discussed in daily clinical meeting and addressed with the specific nurse for correction. Inaccuracy in documentation will be taken to the Quality Assurance committee by the Director of Nurses/Unit Manager monthly for 3 months for review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 514	Continued From page 100	F 514		

In an interview on 07/19/17 at 9:50 AM, Nurse #2 confirmed she looked at Resident #20 ' s penis daily. She stated she thought he had a small tear on his admission but it did not look like it did today. Nurse #2 stated his catheter was changed monthly on night shift and the penile tear should have been reported when it was observed during his catheter change.

In an interview on 07/19/17 at 10:50 AM, Nurse #3 stated she worked third shift but she had not observed his penis in probably a month. She stated the other nurse who worked nights usually changed his urinary catheter. She confirmed Resident #20 ' s catheter was documented changed by the other night nurse on 7/17/17 on third shift.

In a telephone interview on 07/19/17 at 3:10 PM, Nurse #6 confirmed she worked nights and worked third shift on 7/17/17. She stated she had changed Resident #20 ' s urinary catheter in the past but not recently. Nurse #6 was reminded she documented on his TAR she changed his urinary catheter Monday night on 07/17/17. Nurse #6 stated she did not change his catheter on 07/17/17 as documented. She was unable to offer an explanation as to why she initialed off on the TAR that she changed Resident #20 ' s urinary catheter when on interview, she stated she did not. She stated she thought she changed his urinary catheter a month or so ago and had observed pus and blood at his urethra but had not noted the penile tear.

In an interview on 7/19/17 at 4:20 PM, NA #14 stated it was her first day back on the 200-hall assignment after a 3-month rotation on another

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 514	Continued From page 101 hall. The Director of Nursing (DON) and NA #14 were observed assessing Resident #20 ' s penis. The DON pulled back Resident #20 ' s foreskin and testicles to reveal the penile tear. NA #14 stated "it wasn ' t like that 3 months ago". The DON stated she was unable to recall if it had worsened since she last observed it a "few weeks ago". In a nursing note dated 7/19/17 at 4:59 PM which read Resident #20 ' s urinary catheter was changed without difficulty. In an interview on 07/21/ at 10:40 AM, the Administrator stated her expectation that if the nurse documented she changed Resident #20 ' s urinary catheter on 7/17/17, she would have completed a urinary catheter change.	F 514		
F 520 SS=G	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance	F 520		8/11/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 520	Continued From page 102 committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations staff interviews, and record review the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place in June, 2016 following a recertification survey and subsequently recited in July 2017 on the current recertification and complaint survey. The recited deficiencies were in the area of notification of change (F157) and provide services according to the care plan (282). The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance	F 520	The facility's Quality Assurance Committee failed to implement, monitor and revise as needed the action plan developed for the recertification survey dated June 2016 in order to achieve and sustain compliance. All residents residing in the facility have the potential to be affected. On 7/20/17 the V.P of Operations in-serviced the department managers related to the appropriate functioning of the monthly QA Committee (Administrator, DON/Infection Control, MDS nurse, Maintenance Director, Dietary Manager, Social Worker, Medical Records,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 520	Continued From page 103 (QA) Program. The Findings Included: This tag is cross referenced to F157- Based on observations, staff and physician interviews and record review, the facility failed to notify the physician for a change in condition of a urinary catheter insertion site (urethra) for 1 (Resident #20) of 1 residents reviewed for urinary catheters. F282-Based on observation, staff interview and record review, the facility failed to ensure a care planned intervention for securing a urinary catheter to prevent injury for 1 of (Resident #20) 1 reviewed for urinary catheters. The Administrator was interviewed on 7/21/17 at 11:21 AM. She stated that the QA committee met monthly. Her expectation was for the QA committee to meets monthly and identify areas of concern, do a root cause analysis and develop a plan and then audit and monitor that plan and then discuss the outcome.	F 520	Housekeeping, Admissions Director, staff nurse and nursing assistant) and the purpose of the committee to include identifying issues related to quality assessment and assurance activities as needed and developing and implementing appropriate plans of action for identified facility concerns. Findings and results of the QI tool with be reviewed by the monthly QI committee and the quarterly Executive QA Committee will review trends, corrective actions taken and the dates of completion. The QA committee will develop and implement appropriate plans of action to correct and identify quality deficiencies to include accidents, care plans, neglect, administration and QA. The quarterly Executive QA Committee, to include the Medical Director and Pharmacy consultant, and all members of the QA committee will validate the facility's progress in correction of deficient practices or identified concerns. The quarterly Executive QA Committee meeting agenda, resulting plans of correction, and audit results will be documented in the meeting minutes. The administrator will be responsible for ensuring QA Committee concerns and recommendations are addressed through further training or other interventions. The administrator or DON will report back to the Executive QA Committee at the next quarterly meeting.	