| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| E 000 | Initial Comments<br><br>An unannounced recertification and complaint investigation survey was conducted on 07/08/19 through 07/12/19. The facility was found in compliance with the requirement CFR 483.73 Emergency Preparedness. Event ID#LOKE11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced recertification and complaint survey were conducted 07/08/19 through 07/12/19. 7 out of 7 complaint allegations were unsubstantiated. Event ID #L0KE11. | F 000 | | |
| F 558 SS=D | Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)<br><br>§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, resident and staff interviews, and record review, the facility failed to provide a bed sheet as requested by 2 of 2 sampled residents (Resident #29 and Resident #12) reviewed for accommodation of needs.<br><br>Findings included:<br><br>1. A review of the medical record revealed Resident #29 was admitted on 02/11/19 with diagnosis which included anemia, malnutrition and hypertension.<br><br>The quarterly Minimum Data Set (MDS) dated 05/21/19 revealed Resident #29 was cognitively | F 558 | Magnolia Lane nursing and rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.<br><br>Magnolia Lane nursing and rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it | 8/8/19 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 08/02/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 558 | Continued From page 1 | F 558 | | |

intact and required extensive two-person assistance for most Activities of Daily Living (ADL).

Review of a document entitled "Directions for Use from Direct Supply" regarding use of air mattress and bed linens revealed the following statements: Deep-pocketed sheets are recommended. Seven-inch deep fitted sheets are recommended. Multiple layering of linens or under pads beneath the resident can negatively affect the mattress's pressure management capabilities and should be avoided unless recommended by a caregiver.

An observation on 07/08/19 at 3:28 PM revealed Resident #29 lying on a mattress with no bed sheet present. A second observation on 07/10/19 at 11:09 AM revealed Resident #29 lying on a mattress with no bed sheet. Tan matter was observed smeared on the mattress.

On 07/10/19 at 11:09 AM an interview was conducted with Resident #29 whom stated she would prefer a bed sheet on her mattress.

On 07/10/19 at 11:10 AM an interview was conducted with Nurse #1. Nurse #1 stated after looking at Resident #29's mattress it was dirty and needed to be cleaned. She stated nursing staff were told not to place bed sheets onto the air mattresses due to state regulations.

On 07/10/19 at 11:12 AM an interview was conducted with the Director of Nursing (DON). The DON stated she believed they were not supposed to apply bed sheets to the air mattresses however was pulling the manufacturers recommendations to verify. She stated she had observed Resident #29's mattress

constitute an admission that any deficiency is accurate. Further, Magnolia Lane reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.

F558 Reasonable Accommodations Needs/Preferences

On 7/11/19 facility placed bed sheets on beds with air mattresses

A 100% audit was completed by Director of Nursing on 7/31/19 for all residents who had air mattresses to ensure they have a bed sheet. Any negative findings were immediately addressed.

100% of nursing staff were in-serviced by the treatment nurse by 8/1/19 to ensure that all residents who have an air mattress have bed sheets

The Director of Nursing, Assistant Director of Nursing, Treatment Nurse, and/or administrator will complete an audit of all residents with air mattresses 5 times per week for 2 weeks, then weekly for 4 weeks, then monthly for 1 month to

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| F 558 | Continued From page 2<br>in dirty condition and expected staff to clean the mattresses daily.<br><br>A follow up interview on 07/11/19 at 1:12 PM conducted with the DON revealed the manufacturers recommendations included use of a bed sheet applied to the resident's air mattresses. The DON stated the facility should have been following the recommendations and providing the residents with a bed sheet.<br><br>On 07/12/19 at 11:07 AM an interview was conducted with the Administrator. He stated he was not aware of his staff not using bed sheets on the air mattresses. The interview revealed he was unsure as to why they were not using the bed sheets however stated he would address the issue and the faciltiy would follow the manufacturers recommendations allowing the residents to have a bed sheet.<br><br>2. Resident #12 was admitted to the facility on 5/18/18 with a diagnosis of Hemiplegia and Hemiparesis following Cerebrovascular Disease affecting left non-dominant side and right dominant side.<br><br>Review of the Annual Minimum Data Set (MDS) Assessment dated 4/12/19 revealed Resident #12 was cognitively intact and required extensive physical assistance with bed mobility and personal hygiene. Resident #12 was totally dependent on staff for transfer, toilet use and bathing. Resident #12 had impairments on the left upper extremity and on both lower extremities. Resident #12 was always incontinent of urine and bowel.<br><br>Review of Resident #12's Care Plan dated | F 558 | determine if bed sheets are on bed with air mattresses. This audit will be documented on the air mattress audit tool.<br><br>The Administrator will review the air mattress audit tools with the QI Committee monthly for 3 months for follow up and recommendations or continuation as indicated.<br><br>The Director of Nursing is responsible for implementing the acceptable plan of correction | |

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| F 558 | Continued From page 3 | F 558 | | |

5/15/19 revealed an air mattress was started on 5/31/18 due to increased risk for skin breakdown.

Review of a document entitled "Directions for Use from Direct Supply" regarding use of air mattress and bed linens revealed the following statements: Deep-pocketed sheets are recommended. Seven-inch deep fitted sheets are recommended. Multiple layering of linens or under pads beneath the resident can negatively affect the mattress's pressure management capabilities and should be avoided unless recommended by a caregiver.

An observation and interview with Resident #12 were conducted on 7/8/19 at 2:47 PM. Resident #12 asked why she can't have a bed sheet. She stated she was told that it was due to her having an air mattress, and that it was according to state regulations that if she had an air mattress, she was not allowed to have a bed sheet. Resident #12 further stated she has never had a bed sheet since admission and she has asked the staff at least once a week when they gave her a bed bath, but she was given the same answer each time. An air mattress was observed being used by Resident #12 with no bed sheet on the bed.

Another observation and interview were conducted on 7/9/19 at 8:27 AM with Resident #12. She was observed lying in bed with no bed sheet. She had a reusable underpad underneath her bottom area. Resident #12 stated she spent all her time in bed and did not like to get up. She stated she wanted a bed sheet to cover her bed because she gets sweaty and the air mattress gets sticky under her head.

An interview with Nurse #1 on 7/10/19 at 10:35 AM revealed Resident #12 has been requesting

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Continued From page 4

for a bed sheet, but Nurse #1 has been told by nursing management that Resident #12 was not allowed to have one due to her having an air mattress. Nurse #1 stated she was not sure if this was based on the manufacturer's recommendations or from what the Hospice nurse has said about the use of air mattress and bed sheets. She further stated Resident #12 was not receiving care from Hospice but she has had an air mattress since admission.

An interview with Nurse Aide (NA) #2 on 7/10/19 at 10:45 AM revealed he was familiar with Resident #12. NA #2 stated Resident #12 used to have a bed sheet until recently when nursing management told them she could no longer have one due to her having an air mattress. NA #2 further stated he was not sure why but Resident #12 continued to have a reusable underpad underneath her.

An interview with NA #3 on 7/10/19 at 2:39 PM revealed Resident #12 usually stayed in bed and did not like to get up. NA #3 stated Resident #12 was not supposed to have a fitted sheet because they were told by nursing management that the use of fitted sheet defeated the purpose of the air mattress. NA #3 further stated that this practice had started about a year ago.

An interview was conducted with the Director of Nursing (DON) on 7/11/19 at 7:26 AM. The DON stated it hasn't been brought to her attention that Resident #12 has been requesting for a bed sheet. She stated they have started a couple of months ago a policy regarding the use of air mattress and bed sheets. She said they were not allowing residents with an air mattress to have a bed sheet because they believed it might interfere

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| F 558 | Continued From page 5<br>with the purpose of the air mattress.<br><br>A follow-up interview with the DON was conducted on 7/11/19 at 1:08 PM after review of the manufacturer's recommendations regarding the air mattress and bed sheet use. The DON stated the policy started when the Hospice nurse had come to the facility and told them bed sheets were not recommended to be used with an air mattress. The DON stated it was unclear as to what type of air mattress this direction applied to, and they have only been using the reusable underpads since then. The DON stated they have not pulled and reviewed the manufacturer's recommendations regarding the air mattress that the facility was using prior to this day. The DON stated they found out today that they should have been using a fitted sheet to the air mattresses. She said that she spoke with Resident #12 prior to this interview and found out that Resident #12 has been requesting for a fitted sheet which they have provided to her today.<br><br>An interview conducted with Administrator on 7/12/19 at 11:42 AM revealed he was not sure why they have not checked the manufacturer's recommendations regarding the air mattress use. He stated the direction came from a suggestion from the Hospice nurse which they had followed for every resident who had an air mattress. The Administrator further stated they have started correcting this issue the day before when they had reviewed the manufacturer's recommendations. | F 558 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments. | F 641 | | 8/5/19 |

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| F 641 | Continued From page 6<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews and record reviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of discharge for 1 of 1 closed records (Resident #56), in the area of restraints for 1 of 1 residents (Resident #7) and in the area of indwelling catheter (Resident #32) reviewed for MDS accuracy.<br><br>The findings included:<br><br>1. Resident #56 was admitted to the facility on 01/16/2019 with multiple diagnoses including hypertension, hyperlipidemia and thyroid disorder.<br><br>Review of the discharge Minimum Data Set (MDS) dated 04/15/19 revealed Resident #56 was discharged to acute hospital with return not anticipated.<br><br>A review of the discharge summary dated 04/15/19 revealed Resident #56 was discharged to home.<br><br>A review Resident #56's care plan dated 01/22/19 revealed a focus area for Resident #56 to return home with home health services. Interventions included establishing a pre-discharge plan with the resident and to revise the plan as needed.<br><br>On 07/11/19 at 7:40 AM an interview was conducted with the Director of Nursing (DON). The interview revealed Resident #56 was never discharged to the hospital. The interview revealed the MDS should have shown Resident #56 had | F 641 | F641 Accuracy of Assessments.<br><br>An MDS modification for Resident #56 was completed on 7/29/19 by the MDS RN Coordinator for properly coding discharge location.<br><br>An MDS modification was developed for Resident #7 on 7/15/19 by the facility consultant for properly coding of positioning device.<br><br>An MDS modification was developed for Resident #32 on 7/15/19 by the facility consultant for properly coding of indwelling catheter.<br><br>A 100% audit was completed by Social Worker on 7/30/19 for all residents who discharged in the last 3 months per their last MDS assessment to ensure MDS is correctly coded for discharge. Any negative findings were immediately addressed.<br><br>A 100% audit was completed by Assistant Director of Nursing on 7/30/19 of residents seated in geriatric chairs. MDS RN Coordinator reviewed assessments for determining accurate coding for positioning devices verses restraints and that MDS and care plan are reflective of resident□s current status. | |

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F 641 Continued From page 7

been discharged to community and was coded as being discharged to the hospital by mistake. The DON stated her expectation was for Resident #56's MDS to be coded correctly reflecting his discharge status.

On 07/11/19 at 11:12 AM an interview was conducted with MDS Nurse #1. During the interview she stated Resident #56 was not discharged to the hospital on the date 04/15/19 but was discharged to home on that date. The interview revealed the MDS dated 04/15/19 should have reflected Resident #56 was discharged to the community instead of acute hospital. MDS Nurse #1 stated the information was coded in error.

On 07/11/19 at 11:01 AM an interview was conducted with the Administrator. During the interview he stated the facility had issues regarding MDS accuracy and recently hired a new MDS nurse. He stated he expected for Resident #56's MDS to accurately reflect his discharge status of discharging to the community setting not acute hospital.

2. Resident #7 was admitted to the facility 03/30/17 with diagnoses including Huntington's disease and Parkinson's disease.

Review of Resident #7's quarterly Minimum Data Set (MDS) dated 04/18/19 revealed Resident #7 was moderately cognitively impaired and required extensive assistance with bed mobility, transfers, dressing, and personal hygiene. The MDS indicated Resident #7 had functional limitation in range of motion in both sides for upper and lower extremities. The MDS also indicated Resident #7 was unable to walk and was coded as using a

F 641

A 100% audit was completed by MDS RN Coordinator on 7/30/19 of residents to ensure accurate coding of urinary status to include use of urinary catheters. MDS assessments reviewed for determining accurate coding for urinary catheter and that MDS and care plan are reflective of resident□s current status.

The interdisciplinary care plan team was in-serviced by the Administrator on 7/30/19 to ensure that all residents who discharge are coded appropriately on the MDS assessment, all residents who are seated in geriatric chairs have accurately coded MDS, and all residents are accurately coded for urinary status.

The MDS RN Coordinator, Director of Nursing, and/or administrator will complete an audit of 3 discharged residents, all residents coded with restraints, and 3 residents urinary status weekly for 4 weeks beginning 8/5/19, then 3 residents monthly for 3 months to determine if discharged residents are coded properly. This audit will be documented on the care plan/MDS accuracy audit tool.

The Administrator will review the care plan/MDS accuracy audit tools with the QI Committee monthly for 3 months for follow up and recommendations or continuation as indicated.

The MDS RN Coordinator is responsible for implementing the acceptable plan of correction

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| F 641 | Continued From page 8<br>chair that prevented him from rising that was used as a restraint.<br><br>Review of the care plan for falls last updated 06/21/19 revealed Resident #7 was at risk for falls characterized by a history of actual falls, and multiple risk factors related in part to impaired balance, impaired mobility, involuntary movements, poor coordination, and poor safety awareness. The care plan did not indicate the use of a restraint.<br><br>An interview with Nurse #2 on 07/09/19 at 8:59 AM revealed she completed the 04/18/19 quarterly MDS for Resident #7. Nurse #2 stated Resident #7 used a geriatric chair for positioning and was not sure why she coded the geriatric chair as a restraint. She also stated the MDS should have been corrected.<br><br>An interview with the Director of Nursing (DON) on 07/12/19 at 9:12 AM revealed the geriatric chair used by Resident #7 was not a restraint because he was unable to ambulate. The DON stated the MDS was not coded correctly.<br><br>An interview with the Administrator on 07/12/19 at 11:56 AM revealed he expected the MDS to be coded correctly and the MDS should have been corrected.<br><br>3. Resident #32 was admitted to the facility on 10/14/16 with a diagnosis of chronic kidney disease.<br><br>Review of the quarterly Minimum Data Set (MDS) dated 5/24/19 revealed Resident #32 was coded as having an indwelling catheter and urinary continence was marked as not rated due to | F 641 | Compliance date of 8/5/19 | |

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| F 641 | Continued From page 9<br>resident having a catheter.<br><br>Review of Resident #32's Physician Orders and Treatment Administration Record (TAR) for 5/2019 did not indicate use of a urinary catheter.<br><br>Review of Resident #32's Care Plan dated 6/14/19 revealed Resident #32 required extensive to total care with all Activities of Daily Living (ADL) including incontinence care due to being incontinent of bladder.<br><br>An observation of Resident #32 on 7/9/19 at 8:23 AM revealed no use of a urinary catheter.<br><br>An interview with Nurse #1 on 7/9/19 at 9:12 AM revealed Resident #32 did not have a urinary catheter. Nurse #1 stated this information would be reflected on the Physician's Orders and the TAR if Resident #32 had a urinary catheter.<br><br>An interview was conducted with the Director of Nursing (DON) on 7/11/19 at 7:22 AM. The DON stated Resident #32 has never had a urinary catheter while he was a resident at the facility. The DON agreed that the quarterly MDS dated 5/26/19 for Resident #32 was coded inaccurately but she was unsure as to the reason why.<br><br>A phone interview was conducted with Nurse #2 on 7/11/19 at 11:09 AM. Nurse #2 stated she remembered completing the 5/26/19 quarterly MDS for Resident #32. She stated the urinary catheter was coded incorrectly and this was an error.<br><br>An interview was conducted with the Administrator on 7/12/19 at 11:44 AM. The Administrator indicated that the 5/26/19 quarterly | F 641 | | |

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| F 641 | Continued From page 10<br>MDS for Resident #32 was coded inaccurately for presence of urinary catheter. He stated the interim MDS Consultant did audits and was supposed to have corrected and re-submitted the assessment. | F 641 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes. | F 656 | | 8/5/19 |

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| F 656 | Continued From page 11<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, and staff interviews the facility failed to develop a care plan for the use of a geriatric chair for 1 of 1 resident reviewed for positioning (Resident #7).<br><br>Resident #7 was admitted to the facility 03/30/17 with diagnoses including Huntington's disease, abnormal posture, and Parkinson's disease.<br><br>Review of Resident #7's quarterly Minimum Data Set (MDS) dated 04/18/19 revealed Resident #7 required extensive assistance with bed mobility, transfers, dressing, and personal hygiene. The MDS indicated Resident #7 had functional limitation in range of motion in both sides for upper and lower extremities. The MDS also indicated Resident #7 was unable to walk and was coded as using a chair that prevented him from rising.<br><br>Review of the care plan for falls last updated 06/21/19 revealed Resident #7 was at risk for falls characterized by a history of actual falls, and multiple risk factors related in part to impaired balance, impaired mobility, involuntary movements, poor coordination, and poor safety awareness. Resident #7 did not have a care plan | F 656 | F656 Develop/Implement Comprehensive Care Plan.<br><br>A Care Plan were developed for Resident #7 on 7/8/19 by the facility consultant that addresses the use of geriatric chairs for positioning to include a goal and staff interventions.<br><br>A 100% audit was completed by MDS RN Coordinator on 7/31/19 for all residents who had geriatric chairs per their last MDS assessment to ensure they have a care plan in place for the use of geriatric chairs. Any negative findings were immediately addressed.<br><br>The interdisciplinary care plan team was in-serviced by the Administrator on 7/30/19 to ensure that all residents who have a geriatric chair are care planned for the use of geriatric chairs.<br><br>The MDS RN Coordinator, Director of Nursing, and/or administrator will complete an audit of 3 MDS scheduled residents weekly for 4 weeks beginning | |

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| F 656 | Continued From page 12<br>that addressed the use of a geriatric chair for positioning.<br><br>An observation of Resident #7 on 07/08/19 at 5:15 PM revealed he was sitting in a geriatric chair in his room.<br><br>An interview with Nurse #2 on 07/09/19 at 8:59 AM revealed she used to be the MDS Nurse and she completed the quarterly MDS for Resident #7 dated 04/18/19. Nurse #2 stated she was also responsible for developing care plans based on the MDS. Nurse #2 stated Resident #7 used a geriatric chair for positioning. Nurse #2 stated she was not sure if Resident #7 should have had a care plan for use of a geriatric chair for positioning or not.<br><br>An observation of Resident #7 on 07/09/19 at 9:19 AM revealed he was sitting in a geriatric chair in his room.<br><br>An interview with Physical Therapist (PT) #1 on 07/10/19 at 11:33 AM revealed Resident #7 had a history of throwing himself on the floor and a geriatric chair was the best recommendation for positioning him. PT #1 stated the geriatric chair gave Resident #7 the support and security he needed to be safe. PT #1 stated many different interventions had been tried for positioning for Resident #7 but the geriatric chair worked best for him. PT #1 stated she was not sure how long Resident #7 had been using the geriatric chair for positioning.<br><br>An interview with the Director of Nursing (DON) on 07/12/19 at 9:27 AM revealed Resident #7 should have had a care plan in place reflecting why he used the geriatric chair completed by the | F 656 | 8/5/19, then 3 residents monthly for 3 months to determine if geriatric chairs are used and that care plans are accurate. This audit will be documented on the care plan/MDS accuracy audit tool.<br><br>The Administrator will review the care plan/MDS accuracy audit tools with the QI Committee monthly for 3 months for follow up and recommendations or continuation as indicated<br><br>The MDS RN Coordinator is responsible for implementing the acceptable plan of correction<br><br>Compliance date 8/5/19 | |

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| F 656 | Continued From page 13<br>MDS Nurse.<br><br>An interview with the Administrator on 07/12/19 at 11:56 AM revealed the MDS Nurse should have completed a care plan for use of a geriatric chair for positioning for Resident #7. | F 656 | | |
| F 810 SS=D | Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g)<br><br>§483.60(g) Assistive devices<br>The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, and staff interviews the facility failed to provide a modified cup for 1 of 1 resident reviewed for adaptive equipment (Resident #5).<br><br>Findings included:<br><br>Resident #5 was admitted to the facility 07/09/18 with diagnoses including non-Alzheimer's dementia and weakness.<br><br>Review of the occupational therapy discharge instructions dated 09/04/18 revealed Resident #5 was to receive a blue cup with handles for fluids at meals.<br><br>Review of the quarterly Minimum Data Set (MDS) dated 05/21/19 revealed Resident #5 was severely cognitively impaired and was totally dependent for eating. | F 810 | F810 Assistive Devices-Eating Equipment/Utensils<br><br>On 7/8/19 facility provided the 2 handle cup for resident #5<br><br>A 100% audit was completed on 7/29/19 by Dietary Manager for assistive devices to verify for accuracy. Any negative findings were immediately addressed.<br><br>100% of dietary employees were in-serviced on 7/9/19 by Corporate Dietician to ensure that all residents who have an assistive device receive assistive device as ordered. On 8/1/19 100% of dietary staff in-serviced on new tray card system. After 8/1/19 no dietary employee will be allowed to work until in-service completed. New hires will be in-serviced during new hire orientation. | 8/1/19 |

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| F 810 | Continued From page 14<br>The care plan for nourishment last updated 06/18/19 revealed Resident #5 was to receive a no added salt (NAS) diet as ordered.<br><br>An observation of Resident #5's meal tray card on 07/08/19 at 12:55 PM revealed she was to receive adaptive equipment in the form of a 2 handled cup for all 3 meals. An observation of Resident #5's meal tray at the same date and time revealed there was no 2 handled cup on her tray and her tea was in a regular cup.<br><br>An interview of the acting Dietary Manager (DM) on 07/08/19 at 1:03 PM revealed the kitchen was responsible for placing the 2 handled cup on Resident #5's meal tray before the meal tray left the kitchen. The acting DM stated since Resident #5's meal tray card stated she was to receive a 2 handled cup she should have received a 2 handled cup. The acting DM indicated stated Resident #5 usually received the 2 handled cup on her meal tray. The acting DM further stated the trays were checked for accuracy before leaving the kitchen and the 2 handled cup must have gotten missed.<br><br>An interview with Dietary Aide #1 on 07/08/19 at 2:35 PM revealed she performed the last check for accuracy of meal trays before they left the kitchen for the lunch meal on 07/08/19. Dietary Aide #1 stated she just overlooked making sure the 2 handled cup was on Resident #5's meal tray for the lunch meal on 07/08/19 and that Resident #5 usually received the 2 handled cup on her meal tray.<br><br>An interview with the Director of the therapy department on 07/10/19 at 11:50 AM revealed the recommendation for the 2 handled cup from the | F 810 | The Dietary Manager, dietary cook, and/or administrator will complete an audit of all residents with assistive devices 5 times per week for 2 weeks beginning 7/29/19, then weekly for 4 weeks, then monthly for 1 month to determine if assistive devices are sent out as ordered. This audit will be documented on the assistive device audit tool.<br><br>The Administrator will review the assistive device audit tools with the QI Committee monthly for 3 months for follow up and recommendations or continuation as indicated.<br><br>The Dietary Manager is responsible for implementing the acceptable plan of correction<br><br>Compliance date 8/1/19 | |

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| F 810 | Continued From page 15<br>Occupational Therapist (OT) was the most recent recommendation for Resident #5 and if Resident #5's meal tray card stated she was to receive a 2 handled cup she should have received a 2 handled cup.<br><br>An interview with the Administrator on 07/12/19 at 11:56 AM revealed he expected the 2 handled cup to be on Resident #5's meal tray when the meal tray was sent from the kitchen or nursing staff should have obtained the 2 handled cup from the kitchen. | F 810 | | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews and record review, the facility failed to label and date | F 812 | F812 Food Procurement, Store, Prepare/Serve-Sanitary | 8/8/19 |

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| F 812 | Continued From page 16<br>opened items and discard expired food available for use in 1 of 1 reach-in refrigerator and 1 of 1 walk-in cooler in the kitchen, and 1 of 1 nourishment refrigerator.<br><br>Findings included:<br><br>Review of the facility's Food Storage policy last revised on 8/2013 revealed the following statement: All incoming foods will have a delivery date and/or "open date" or "use by" date. When the foods are stored in a container other than the original container, the container will be labeled with the name of the product and an incoming, wash and fill date.<br><br>During the initial tour of the kitchen on 7/8/19 at 9:08 AM to 10:00 AM with Cook #1:<br>1. An observation of the reach-in refrigerator revealed the following:<br>a. A big container of left-over ham with pineapple was not labeled and dated.<br>b. A big container of tomato soup was labeled "discard by 7/1/19."<br>c. A big container of tuna salad was labeled "discard by 7/7/19."<br><br>2. An observation of the walk-in cooler revealed the following:<br>a. A big container of pimiento spread was not labeled and dated.<br>b. A big container of cucumber salad was not labeled and dated.<br>c. An opened package of smoked ham was placed in an unlabeled and undated bag.<br>d. An opened package of sliced cheese was placed in an unlabeled and undated bag.<br>e. A box of 20 tomatoes dated 6/7/19 had one tomato that was completely covered with mold. | F 812 | On 7/8/19 facility disposed of items not labeled and dated.<br><br>A 100% audit was completed on 7/19/19 by Dietary Manager to assure that no unlabeled or outdated items were in the kitchen or nourishment room areas. Any negative findings were immediately addressed.<br><br>100% of dietary staff were in-serviced on 7/9/19 by Corporate Dietician on labeling and dating of food items.<br><br>The Dietary Manager, dietary cook, and/or administrator will complete an audit on all food items to assure they are labeled and dated as per regulation 5 times per week for 2 weeks, then weekly for 4 weeks, then monthly for 1 month. This audit will be documented on the daily dietary audit tool.<br><br>The Administrator will review the daily dietary audit tools with the QI Committee monthly for 3 months for follow up and recommendations or continuation as indicated.<br><br>The Dietary Manager is responsible for implementing the acceptable plan of correction | |

F 812 Continued From page 17 F 812

Interview with Cook #1 on 7/8/19 at 9:08 AM who stated the cooks were responsible for checking the reach-in refrigerator and the walk-in cooler, but she hasn't checked both earlier that morning yet. She stated all the unlabeled food items should have been labeled and dated at the time they were opened and placed in either the reach-in refrigerator or walk-in cooler. Cook #1 further stated the tomato soup and tuna salad in the reach-in refrigerator were expired and should have been discarded. She stated the box of tomatoes in the walk-in cooler should have been discarded prior to 7/8/19. Cook #1 discarded all expired and unlabeled food items in the reach-in refrigerator and walk-in cooler. Cook #1 further stated that she had been off the week before, and that the Dietary Manager was out that day and has been out for 2 weeks.

An interview conducted with the Consultant Dietary Manager (CDM) on 7/9/19 at 2:20 PM revealed all the unlabeled food items that were found during the initial tour in the reach-in refrigerator and walk-in cooler should have been labeled and dated when they were placed there. She further stated the tomato soup and tuna salad should have been discarded by the "discard by" date. She said the box of tomatoes should have been discarded before 7/8/19. The CDM further stated she had not been in the facility in 5-6 weeks. She was not sure where the Dietary Manager was and was not aware that the Dietary Manager has been out.

On 7/11/19 at 2:20 PM, an observation of the nourishment refrigerator was made with the Director of Nursing (DON). A left-over food item in a plastic bag marked with a resident's name

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| F 812 | Continued From page 18<br>and dated 7/7/19 was on the bottom part of the refrigerator. A take-out box with a resident's name and dated 7/7/19 was in the freezer. The temperature log posted on the refrigerator revealed it was last checked on 7/4/19 on day shift.<br><br>During the observation on 7/11/19 at 2:20 PM, an interview with the DON was also conducted. The DON stated she was not sure if the outside food items dated 7/7/19 in the nourishment refrigerator and freezer were supposed to be discarded. The DON stated she would have to check with the CDM. The DON said the dietary aides were responsible for checking the nourishment refrigerator twice a day.<br><br>An interview and follow-up observation with the CDM on 7/11/19 at 3:15 PM of the nourishment refrigerator revealed the refrigerator had been cleaned up and the left-over food items dated 7/7/19 had been discarded. The CDM stated the expired food items should have been discarded 3 days after they were placed in the refrigerator.<br><br>An interview was conducted on 7/11/19 at 3:54 PM with Dietary Aide (DA) #1 who stated the dietary aides were responsible for checking the nourishment refrigerator twice a day. She further stated that she worked on day shift on 7/8/19 and 7/9/19 but forgot to check the refrigerator due to having too much to do in the kitchen on those days. DA #1 stated that she discarded the left-over food item in a plastic bag and the take-out box which were both dated 7/7/19. She said any food brought in from outside the facility and placed in the nourishment refrigerator should be discarded after 3 days. | F 812 | | |

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| F 812 | Continued From page 19<br>An interview conducted with the Administrator on 7/12/19 at 7:54 AM revealed the Dietary Manager had been out for 2 weeks but has delegated the daily inspection of the kitchen to the dietary staff. The Administrator stated it was his expectation that the dietary staff check for labels and make sure every food item in the reach-in refrigerator, walk-in cooler and nourishment refrigerator were dated, and discarded after 3 days of opening or being placed in the refrigerator. | F 812 | | |
| F 880<br>SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, | F 880 | | 8/5/19 |

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| F 880 | Continued From page 20 | F 880 | | |

but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.

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This REQUIREMENT is not met as evidenced by:

Based on observations and staff interviews the facility failed to bag soiled linen in a resident room and prior to removing from a resident room (Resident #50), failed disinfect the top of a soiled linen container, and failed to dispose of a soiled disposable brief by placing it on top of a geriatric chair and leaving the geriatric chair out in the hallway. The facility also failed to sanitize the contaminated geriatric chair for 1 of 2 sampled residents (Resident #27).

Findings included:

A review of Infection Prevention and Control Program (IPCP) last revised 01/22/18 read in part: the objective of the ICPC were to ensure facility personnel handled, stored, processed, and transported linens and laundry to prevent the spread of infection.

1. An observation on 07/09/19 at 2:05 PM revealed soiled linen was lying on the floor of room 97-B and nurse aide (NA) #1 was finishing providing care to Resident #50. NA #1 was then observed to exit room 97, retrieve a linen container from the soiled utility and place the soiled linen container outside room 97. NA #1 retrieved the unbagged linen from 97-B and laid it on top of the soiled linen container and walked up the hall. NA #2 walked by the linen container outside room 97 and picked up the soiled linen and placed the soiled linen in the soiled linen container. When NA #2 picked up the soiled linen to place it in the linen container stool had leaked out onto the lid of the linen container. NA #1 returned to the linen container and observed the stool on top of the soiled linen container and

F 880

F 880 Infection Prevention and Control
On 07/09/19 the soiled linen container on Main Hall was deep cleaned by housekeeping staff and sanitized and Room 97 was mopped and sanitized.
On 07/12/19 geri-chair for resident # 27 was sanitized. Director of Nursing verified that surface wipes were accessible for sanitation.
On 7/15/19 100% of soiled linen containers were cleaned and sanitized by housekeeping

A 100% education was initiated by the Director of Nursing (DON) on 07/29/19 for all nursing staff to discuss handling of soiled linen and appropriate disposal of soiled briefs. This in-service will be completed by 08/05/19. No staff members will be allowed to work past this date if in-service is not completed. New hires will complete in-service during new hire orientation.

Handling of Linen and soiled brief audits will be completed by the Director of Nursing, Assistant Director of Nursing, Treatment Nurse or staff nurse for 2 residents 5 days per week for 4 weeks beginning 8/5/19, then 2 residents weekly for 4 weeks to ensure linen and soiled briefs are being handled appropriately. This audit will be documented on the Infection Control Audit Tool. Any negative findings will be addressed immediately and education will be provided.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345219 | A. BUILDING ______ B. WING ______ | C 07/12/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **MAGNOLIA LANE NURSING AND REHABILITATION CENTER** | **107 MAGNOLIA DRIVE MORGANTON, NC 28655** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 880 | Continued From page 22<br>retrieved a pre-moistened cloth from the bedside chest of Resident #29 and wiped the stool off the top of the linen container and walked up the hall again.<br><br>An interview with NA #1 on 07/09/19 at 2:10 PM revealed she should not have placed the soiled linen on the floor of 97-B and should not have placed the soiled linen on top of the linen container. NA #1 stated the reason she placed the soiled linen in the floor of room 97-B and then on top of the soiled linen container was because she ran out of trash bags. NA #1 stated she had no idea what the top of the soiled linen container should have been cleaned with to remove the stool from the top of the linen container.<br><br>An interview with the Director of Nursing (DON) on 07/09/19 at 2:14 PM revealed all soiled linen should be bagged in resident rooms. The DON stated the soiled linen should not have been placed on top of the linen container and a wipe for surfaces should have been used to clean the top of the soiled linen container.<br><br>An interview with the Administrator on 07/12/19 at 11:56 AM revealed linen should be bagged in resident rooms and not placed on top of the linen container and housekeeping should have been called immediately to clean the top of the soiled linen container.<br><br>2. An observation made on 7/11/19 at 3:41 PM revealed a geriatric chair out in the hallway right outside of Resident #27's room. A soiled disposable brief was on top of the geriatric chair. The door to Resident #27's room was open, and Nurse Aide (NA) #1 was inside the room. When NA #1 was asked to confirm if the disposable | F 880 | The administrator will review the findings of the Infection Control Audit Tool with the QI committee monthly for 3 months for follow up and recommendations or continuation as indicated.<br><br>The Director of Nursing is responsible for implementing the acceptable plan of correction<br><br>Compliance date of 8/5/19 | |

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| F 880 | Continued From page 23<br>brief on the geriatric chair was soiled, NA #1 stated that it was and immediately pulled the geriatric chair back into the room. NA #1 was then observed placing soiled linens on top of the soiled disposable brief while stating that everything was dirty. NA #1 left the room and came back after one minute. NA #1 placed the soiled linens in a plastic bag and the soiled disposable brief in another plastic bag. NA #1 left the room holding the two plastic bags and placed the soiled linen bag into the laundry hamper parked in the hallway and the soiled disposable brief into the trash hamper. NA #1 went to the next room, washed hands and started to put gloves on when she was stopped by the surveyor.<br><br>Interview with NA #1 on 7/11/19 at 3:45 PM revealed NA #1 had just finished placing Resident #27 to bed and providing care to her, and that NA #1 had placed the soiled disposable brief on top of the geriatric chair. NA #1 stated that she should have placed the soiled disposable brief into a bag and not on top of the geriatric chair, but she had run out of plastic bags. NA #1 stated she was going to place the soiled disposable brief into a plastic bag after being completed with care, but she had to push the geriatric chair out into the hallway to make room. NA #1 further stated she was going to clean the geriatric chair after she was finished providing care to all her residents on the hall.<br><br>Interview with Nurse #1 on 7/11/19 at 4:06 PM revealed NA #1 should have placed the soiled disposable brief in a bag and she shouldn't have left it on top of the geriatric chair out in the hallway. Nurse #1 stated the NA were supposed to keep extra plastic bags in the trash cans in the residents' rooms to put the soiled disposable | F 880 | | |

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| F 880 | Continued From page 24<br>briefs in. Nurse #1 further stated Resident #27 did not usually use a geriatric chair, but she must have used it for transport from a medical appointment earlier that day. Nurse #1 stated NA #1 should have cleaned the geriatric chair before she left the room to take care of another resident.<br><br>An interview conducted with the Director of Nursing (DON) on 7/12/19 at 10:47 AM revealed that it was her expectation for staff to bag soiled disposable briefs before they take them out of the room. The DON further stated NA #1 should have cleaned the geriatric chair right away before leaving the room. The DON stated that if NA #1 had run out of the sanitizer wipes on the floor, she should have notified Nurse #1 or the DON, so they could go to the supply room to retrieve more sanitizer wipes to use to clean the contaminated geriatric chair. The DON further stated the facility has identified an issue with infection control and that they have included a monthly training for all staff each month. The DON stated NA #1 was a new employee and had just completed the most recent infection control in-service, but she will follow-up and provide NA #1 with further training.<br><br>An interview conducted with the Administrator on 7/12/19 at 11:49 AM revealed NA #1 should have had a bag with her and that the geriatric chair should have been cleaned immediately or as soon as possible. | F 880 | | |