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	345219	A. BUILDING ______ B. WING ______	C 03/30/2022

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MAGNOLIA LANE NURSING AND REHABILITATION CENTER	107 MAGNOLIA DRIVE MORGANTON, NC 28655

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E 000	Initial Comments An unannounced recertification survey was conducted on 03/28/22 through 03/30/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# LZ7M11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 03/28/22 to 03/30/22. Event ID #LZ7M11. There were 4 intakes associated with the survey NC00182037, NC00186208, NC00182040 and NC00186208. 6 of the 8 allegations were substantiated.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with resident, staff and the Medical Director, the facility failed to assess the ability of a resident to self-administer an inhaler for 1 of 1 resident (Resident #17) reviewed for self-administration of medications. The findings included: Resident #17 was admitted to the facility on 8/16/21 with diagnoses that included chronic respiratory failure with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions) and chronic obstructive pulmonary disease (COPD).	F 554	Magnolia Lane Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Magnolia Lane Nursing and Rehabilitation's response to this statement of deficiencies does not denote agreement with the statement of deficiencies nor does it constitute an	4/23/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 04/22/2022

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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Resident #17's care plan revised on 9/13/21 indicated Resident #17 had potential for or actual ineffective breathing pattern related to COPD and history of respiratory failure. Interventions included to administer medications as ordered. The care plan did not include that Resident #17 was able to administer his own medications.

A review of Resident #17's electronic medical record revealed an assessment entitled, "Medication Self Administration Assessment," dated 11/2/21 was marked as incomplete and was blank.

The Physician's Orders in Resident #17's medical record included an order dated 1/25/22 for Albuterol inhaler - inhale 2 puffs every 6 hours as needed for shortness of breath; prime prior to first use or if unused > 3 weeks; prime by spraying 3 times; shake well and wait 1 minute between each puff. The order did not include to keep the medication at the bedside.

The quarterly Minimum Data Set (MDS) assessment dated 3/12/22 indicated Resident #17 was cognitively intact but had moderate hearing difficulty. Resident #17 required extensive physical assistance with all activities of daily living. No behaviors were indicated.

Further review of Resident #17's medical record revealed an additional physician order dated 3/14/22 to only use the Albuterol inhaler if out of facility and use with spacer.

An observation of Resident #17 on 3/28/22 at 10:01 AM revealed an Albuterol inhaler on his bedside table while he was sleeping in the bed on

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admission that any deficiency is accurate. Further, Magnolia Lane Nursing and Rehabilitation reserves the right to refute any of the deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding.

F554 Resident Self-Administer Medication, clinically appropriate

¿ Resident #17’s Albuterol inhaler medication was removed from his room on 3/29/2022 by Nurse #1. A Medication Self-Administration Assessment was completed by Nurse #1 on 3/29/2022 and Resident #17 was determined to be unsafe to self-administer the Albuterol inhaler due to inability to follow the physician order for how often to use the inhaler.

¿ On 4/18/2022 the Social Worker and Admissions Director conducted a facility wide room check resulting in no medications found in any resident room. Beginning on 4/18/2022 all residents with a BIMS of 13 or higher were identified and interviewed by the Director of Nursing/Minimum Data Set Coordinator (MDS) to assess if they are interested in self-administering their medication. All residents interviewed, declined wanting to give themselves their medication.

¿ On 4/18/2022 the Administrator conducted an in-service with the nursing department to include all Registered Nurses (RN), Licensed Practical Nurses (LPN) and certified nursing assistants (CNA). The in-service reminded staff that no medication is permitted to be left in a

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F 554	Continued From page 2 his left side. A second observation of Resident #17 on 3/28/22 at 2:46 PM revealed him still asleep and the Albuterol inhaler was still on his bedside table. A third observation of Resident #17 on 3/29/22 at 9:02 AM revealed him awake and drinking water from his pitcher. The Albuterol inhaler remained on top of his bedside table. Nurse #1 walked into Resident #17's room to give his oral medications. After Nurse #1 exited Resident #17's room, an interview was conducted with Resident #17 on 3/29/22 at 9:07 AM. Resident #17 stated he was hard of hearing and could not understand what the surveyor was talking about when he was questioned about his inhaler. Resident #17 denied that he had an Albuterol inhaler at the bedside. The Albuterol inhaler was no longer on his bedside table during this interview. An interview with Nurse #1 on 3/29/22 at 9:10 AM revealed she had not been aware that Resident #17 had an Albuterol inhaler at the bedside. During the interview, Nurse #1 went back into Resident #17's room and found an Albuterol inhaler. Nurse #1 told Resident #17 that she would need to take the inhaler from him because he couldn't keep it at the bedside. She stated that Resident #17 knew he was not supposed to keep his inhaler at the bedside. Nurse #1 also stated she did not know how Resident #17 obtained his Albuterol inhaler and if it was safe for him to self-administer his inhaler. An interview with Nurse #2 on 3/30/22 at 12:27 PM revealed she worked on 3/28/22 on the day shift with Resident #17 but she didn't notice his	F 554	residents' room, unless 1) there is a physician order, 2) there is a completed Medication Self-Administration Assessment stating the resident can safely self-administer medications, 3) there is a physician assessment, and 4) the resident has the ability to secure the medication in a locked compartment. Beginning 4/18/2022 the Director of Nursing (DON) will interview new residents with a BIMS of 13 or above to inquire if the resident is interested and is safe to self-administer medication. The Medication Administration Assessment will be documented in the resident's electronic health record. Beginning on 4/18/2022 this training will be provided to all new hires and agency nursing staff during orientation. ¿ The DON/Staff Development/Administrator will complete audits using the Medication in Room Audit Tool. This will be done 1-time weekly x 4 weeks then 1-time monthly x 2 months. Results of the audit will be shared with the Quality Assurance Performance Improvement (QAPI) members monthly x 2 months or until a time determined by the QAPI members for sustained compliance. ¿ Alleged date of compliance is 4/23/22.	

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F 554	Continued From page 3 Albuterol inhaler that was on top of his bedside table. Nurse #2 stated he had sometimes asked her to use his Albuterol inhaler, but he had never requested for her to leave it at the bedside. Nurse #2 also stated she wasn't sure if Resident #17 had been assessed to self-administer medications, but she didn't think he would be able to because he had memory issues. Nurse #2 stated she could find out for sure if he was safe to administer his own medications by completing a medication self-administration assessment for Resident #17. An interview with Medication Aide (MA) #2 on 3/29/22 at 8:18 PM revealed Resident #17 sometimes asked for his Albuterol inhaler, and he had tried before to request her to leave his inhaler at the bedside, but she stated she never left his inhaler as he had requested. MA #2 stated she did not notice Resident #17's Albuterol inhaler on top of his bedside table when she gave his 8 PM medications on 3/28/22. MA #2 also stated she was not sure how Resident #17 obtained his Albuterol inhaler and kept it at his bedside. MA #2 stated that it was not safe for Resident #17 to self-administer his medications. An interview with the Medical Director (MD) on 3/30/22 at 4:48 PM revealed he had ordered on 3/14/22 for Resident #17 to only use his Albuterol inhaler when out of the facility and to use it with a spacer based on a pharmacy recommendation. Resident #17 also had an order for Albuterol nebulizer treatments that was scheduled four times a day in addition to the Albuterol inhaler as needed. The pharmacist consultant had recommended not to use both forms of the same medication at the same time. The MD stated Resident #17 was only supposed to use his	F 554		

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F 554	Continued From page 4 Albuterol inhaler when he went out of the facility, and they were instructed to send it with him along with a spacer that he could use with the inhaler because Resident #17 suffered from air hunger sometimes and needed quick relief. The MD also stated Resident #17 could only use his Albuterol inhaler no closer than every 4 hours and he didn't think Resident #17 would be able to follow this direction. The MD added that using Albuterol inhaler more than the prescribed times could overstimulate his heart and cause him to have a rapid heart rate. The MD stated he didn't think Resident #17 was safe to self-administer his medications. An interview with the Director of Nursing (DON) on 3/30/22 at 5:44 PM revealed a staff member probably forgot to pick up the Albuterol inhaler from Resident #17 who was known for trying to hide his inhaler from staff. The DON stated she was not aware that Resident #17 had an order to only use his Albuterol inhaler when out of the facility. Resident #17 should not keep his inhaler at the bedside, and she knew the MD would not allow it because it was not safe for him to do so. Resident #17 was not safe to self-administer his medications and she needed to consult with the MD regarding his order to use the Albuterol inhaler when out of the facility.	F 554		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.	F 561		4/23/22

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§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.

§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.

§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.

§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on record reviews, resident, and staff interviews, the facility failed to honor smoking times and residents' choice to smoke as scheduled every day for 3 of 4 residents (Resident #31, #3 and #7) who were identified as supervised smokers.

The findings included:

1. Resident #31 was admitted to the facility on 05/25/21.

Resident #31's quarterly Minimum Data Set (MDS) dated 02/07/22 revealed she was moderately cognitively impaired and required

Provider's Plan of Correction:

F561 Self Determination
¿ Resident #31, Resident #3, and Resident #7 were given the opportunity to have a smoke break at 8:00 p.m. on 3/29/22.
¿ On 4/13/2022 the Administrator and Director of Nursing established the designated smoking times of 9:00 a.m., 1:00 p.m., 4:00p.m., and 8:00 p.m. with a staff member assisting the residents out to smoke. The Administrator, Director of Nursing, and Minimum Data Set Coordinator reviewed the active smokers list on 4/13/2022, the facility currently has 12 supervised smokers. On 3/30/2022 the

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limited assistance of 1 staff member with most activities of daily living. She required supervision for locomotion in her wheelchair and was coded for smoking.

Resident #31's care plan dated 03/03/22 revealed a plan of care for smoking. The interventions included to evaluate the resident's ability to smoke safely on a consistent and regular basis, observe for potential violations of the smoking policy and document and report observations to the Administrator or Administrative staff, oxygen removal prior to smoking per physician ' s order, provide resident education on smoking policy, provide resident with smoking apron and upon return of smoking materials by resident, ensure materials are placed in secured storage area.

Resident #31's Smoking Evaluation dated 03/16/22 indicated Resident #31 was an unsafe smoker and required direct supervision while smoking.

During the entrance conference with the Administrator on 03/28/22 at 10:54 AM, it was discussed that the designated smoking times were at 9:00 AM, 1:00 PM, 4:00 PM and 8:00 PM.

A list of active smokers was provided on 03/28/22 by the facility. The form listed Resident #31 as a smoker.

Interview on 03/28/22 at 10:41 AM with Resident #31 revealed the smokers were not always provided an 8:00 PM smoke break. Resident #31 stated they were supposed to go out 4 times a day and were not always allowed to go out 4 times because there was not enough staff to take them out for their smoke breaks. The resident

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Social Worker initiated education to the supervised smokers on the specified designated smoking times. This education was completed on 3/30/2022.

¿ On 4/20/2022 the Director of Nursing or Administrator will review the staffing each morning and ensure a staff member is assigned to accommodate residents for each smoking time for that day. Beginning on 4/20/2022 the Director of Nursing or Administrator began reviewing the smoking log the following day to ensure residents have had their opportunity for a smoke break during each designated time. Beginning on 4/20/2022 the Administrator instructed the staff to notify the Administrator or the DON immediately if unable to take the residents out to smoke, so that alternate arrangements can be made to take out the smokers. Beginning on 4/18/2022 this training will be provided to all new hires and agency nursing staff during orientation. 4/20/2022 Administrator in-serviced all staff on the smoking log and how to document the smoke breaks including names of the residents that participated. This log is an on-going tool for monitoring the smoke breaks. Staff are aware to reach out to DON or Administrator if unable to comply with a smoke break and the numbers are at all nursing stations and posted on the daily schedule.

¿ Beginning on 4/20/2022 the Social Worker or Admissions Director will complete audits using the Self Determination for Smoking tool. This will be done 1-time weekly x 6 weeks then 1-time monthly x 2 months. Results of

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F 561	Continued From page 7 further stated they had missed the 4:00 PM break at times but had missed the 8:00 PM break a lot more. Resident #31 stated these breaks were the activity that she looked forward to the most and said the facility should have staff to take them out at least 4 times a day to smoke. Interview on 03/29/22 at 10:56 AM with Nurse Aide (NA) #2 revealed she usually worked on the day shift but had to stay over sometimes for the evening shift because they sometimes had only 2 NAs for the whole facility. NA #2 stated she never took the residents out for their smoke breaks because she was always busy with patient care. NA #2 also stated she had heard the smokers had not been able to go out to smoke especially at 8:00 PM because they didn't have enough staff to take them out. Interview on 03/29/22 at 2:04 PM with Nurse #1 revealed the smokers did not always get to go out to smoke at 8:00 PM because the facility had horrible staffing on the evening shift. Nurse #1 stated the facility always had one nurse aide on each side for the evening shift and that was not enough to adequately take care of all the residents. Nurse #1 also stated assisting the residents out to smoke took about 45 minutes to an hour even though the actual smoking time was only 30 minutes because of the level of assistance required by the residents from staff. Interview on 03/29/22 at 4:43 PM with NA #4 revealed she usually worked on the evening shift from 3:00 PM to 11:00 PM and there were times they could not take the smoking residents out for the smoke break at 8:00 PM. NA #4 stated there had been times when they were unable to take the smokers out for their break at 4:00 PM and	F 561	audit will be shared with the Quality Assurance Performance Improvement (QAPI) members monthly x 2 months or until a time determined by the QAPI members for sustained compliance. The Administrator is responsible for sustained compliance. ¿ Alleged date of completion is 4/23/22.	

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said the smokers get angry when staff tell them they can ' t take them out due to other resident care.

Interview on 03/29/22 at 8:41 PM with NA #5 revealed she usually worked on the evening shift from 3:00 PM to 11:00 PM or 7:00 PM to 7:00 AM. She stated there had been times when the Director of Nursing (DON) had told the smoking residents at 4:00 PM that would be their last smoke break for the day due to staffing issues, but the residents still lined up at 8:00 PM and they got mad when they couldn ' t go out at 8:00 PM to smoke.

Interview on 03/30/22 at 5:44 PM with the Director of Nursing (DON) revealed there had been very few times the smoking residents missed their smoke breaks at 4:00 PM but 8:00 PM had been hard due to short staffing. The Social Worker (SW) and Nurse #1 had been good about staying over and taking the residents out to smoke at 8:00 PM and sometimes earlier but said they didn ' t always stay over. The DON stated when there were only 2 NAs for the whole facility in the evening and the nurse was giving medications, their priority was patient care and not taking the smoking residents out to smoke.

2. Resident #3 was admitted to the facility on 5/22/19.

Resident #3's care plan revised on 07/01/21 indicated Resident #3 smoked occasionally and required supervision due to the resident being unable to propel herself to the smoking area independently. The goal was for Resident #3 to continue to use smoking materials safely through the next review date. Interventions included

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evaluation of the residents continued ability to smoke safely on a consistent and regular basis.

The quarterly Minimum Data Set (MDS) assessment dated 3/11/22 indicated Resident #3 was cognitively intact and required extensive physical assistance with all activities of daily living.

Resident #3's Smoking Evaluation dated 3/16/22 indicated Resident #3 was an unsafe smoker and required direct supervision while smoking.

During the entrance conference with the Administrator on 3/28/22 at 10:54 AM, it was discussed that the designated smoking times were at 9:00 AM, 1:00 PM, 4:00 PM and 8:00 PM.

An interview with Resident #3 on 3/29/22 at 9:34 AM revealed she did not always get to go out and smoke at the 8:00 PM smoking time. She stated the facility often did not have a staff member to take the residents outside. Resident #3 stated she wanted to go out and smoke at 8:00 PM as designated.

An interview with Nurse Aide (NA) #2 on 3/29/22 at 10:56 AM revealed she usually worked on the day shift but had to stay over sometimes for the evening shift because they sometimes had only 2 nurse aides for the whole facility. NA #2 stated she never took the smoking residents out for their smoke breaks because she was always busy with patient care. NA #2 also stated she had heard that the smokers had not been able to go out to smoke especially at 8:00 PM because they didn't have enough staff to take them out.

An interview with Nurse #1 on 3/29/22 at 1:54 PM

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revealed the smokers did not always get to go out to smoke at 8:00 PM because the facility had horrible staffing on the evening shift. Nurse #1 stated the facility always had one nurse aide on each side for the evening shift and that was not enough to adequately take care of all the residents. Nurse #1 also stated assisting the residents out to smoke took about 45 minutes to an hour even though the actual smoking time was only 30 minutes because of the level of assistance required by the residents from staff.

An interview with NA #6 on 3/29/22 at 5:03 PM revealed she usually worked on the evening shift from 3:00 PM to 11:00 PM and there had been many times when they could not take the smoking residents out for their smoke breaks at 8:00 PM. NA #6 stated there had been times before that they couldn't take them out for smoking at 4:00 PM either.

An interview with NA #5 on 3/29/22 at 8:41 PM revealed there had been times when the Director of Nursing (DON) had told the smoking residents at 4:00 PM that it would be their last smoke break for the day due to staffing issues, but the residents still lined up by the door at 8:00 PM and they got mad when they couldn't go out at 8:00 PM to smoke.

An interview with NA #7 on 3/29/22 at 8:18 PM revealed there had been plenty of times that they had not been able to take the smokers out at 8:00 PM because they did not have enough help. NA #7 stated they usually allowed them to smoke an extra cigarette at 4:00 PM and told them that they won't be able to take them out again at 8:00 PM but the residents still lined up at the door at 8:00 PM.

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An interview with the Director of Nursing (DON) on 3/30/22 at 5:44 PM revealed there had been very few times that the smoking residents missed their smoke breaks at 4:00 PM but 8:00 PM had been hard due to short staffing. The Social Worker and Nurse #1 had been good about staying over and taking the residents out to smoke at 8:00 PM but they didn't always do so. When there were only 2 nurse aides for the whole facility in the evening and the nurse was giving medications, their priority was patient care.

3. Resident #7 was admitted to the facility on 5/13/21.

Resident #7's care plan revised on 6/28/21 indicated Resident #7 required supervision while smoking related to history of seizures. Interventions included to assist Resident #7 to designated smoking areas during established facility smoking times.

The quarterly Minimum Data Set (MDS) assessment dated 1/7/22 indicated Resident #7 was cognitively intact and required extensive physical assistance with all activities of daily living.

Resident #7's Smoking Evaluation dated 3/16/22 indicated Resident #7 was an unsafe smoker and required direct supervision while smoking.

During the entrance conference with the Administrator on 3/28/22 at 10:54 AM, it was discussed that the designated smoking times were at 9:00 AM, 1:00 PM, 4:00 PM and 8:00 PM.

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An interview with Resident #7 on 3/28/22 at 10:25 AM revealed smoke breaks sometimes got cancelled when the facility did not have a nurse aide to supervise the residents who smoked. Resident #7 stated he sometimes did not get to go out for a smoking break at 4:00 PM and most of the time missed the 8:00 PM smoking break because there was no one to take the smokers out at those times. Resident #7 stated smoking was very important to him, and he didn't like not having the 4 smoking times that the facility had designated for the smokers.

An interview with Nurse Aide (NA) #2 on 3/29/22 at 10:56 AM revealed she usually worked on the day shift but had to stay over sometimes for the evening shift because they sometimes had only 2 nurse aides for the whole facility. NA #2 stated she never took the smoking residents out for their smoke breaks because she was always busy with patient care. NA #2 also stated she had heard that the smokers had not been able to go out to smoke especially at 8:00 PM because they didn't have enough staff to take them out.

An interview with Nurse #1 on 3/29/22 at 1:54 PM revealed the smokers did not always get to go out to smoke at 8:00 PM because the facility had horrible staffing on the evening shift. Nurse #1 stated the facility always had one nurse aide on each side for the evening shift and that was not enough to adequately take care of all the residents. Nurse #1 also stated assisting the residents out to smoke took about 45 minutes to an hour even though the actual smoking time was only 30 minutes because of the level of assistance required by the residents from staff.

An interview with NA #6 on 3/29/22 at 5:03 PM

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revealed she usually worked on the evening shift from 3:00 PM to 11:00 PM and there had been many times when they could not take the smoking residents out for their smoke breaks at 8:00 PM. NA #6 stated there had been times before that they couldn't take them out for smoking at 4:00 PM either.

An interview with NA #5 on 3/29/22 at 8:41 PM revealed there had been times when the Director of Nursing (DON) had told the smoking residents at 4:00 PM that it would be their last smoke break for the day due to staffing issues, but the residents still lined up by the door at 8:00 PM and they got mad when they couldn't go out at 8:00 PM to smoke.

An interview with NA #7 on 3/29/22 at 8:18 PM revealed there had been plenty of times that they had not been able to take the smokers out at 8:00 PM because they did not have enough help. NA #7 stated they usually allowed them to smoke an extra cigarette at 4:00 PM and told them that they won't be able to take them out again at 8:00 PM but the residents still lined up at the door at 8:00 PM.

An interview with the Director of Nursing (DON) on 3/30/22 at 5:44 PM revealed there had been very few times that the smoking residents missed their smoke breaks at 4:00 PM but 8:00 PM had been hard due to short staffing. The Social Worker and Nurse #1 had been good about staying over and taking the residents out to smoke at 8:00 PM but they didn't always do so. When there were only 2 nurse aides for the whole facility in the evening and the nurse was giving medications, their priority was patient care.

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F 656	Continued From page 14	F 656		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §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 - (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 (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). (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. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (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	F 656		4/23/22

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F 656	Continued From page 15 entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to develop a comprehensive care plan for smoking. This was for 1 of 4 residents reviewed for accidents (Resident #6). The facility also failed to implement a hand roll as specified in the comprehensive care plan for 1 of 3 residents reviewed for range of motion (Resident #41). The findings included: 1. Resident #6 was admitted to the facility on 09/03/21 and readmitted on 11/15/21. Review of Resident #6's care plan revised on 01/05/22 revealed there was no resident centered care plan that addressed smoking. Review of Resident #6's Smoking Evaluation dated 03/21/22 revealed Resident #6 was an unsafe smoker and required direct supervision while smoking. The evaluation further revealed Resident #6 had been educated on the smoking policy and a copy provided and her care plan was reviewed and revised as necessary. Observation on 03/29/22 at 4:10 PM revealed Resident #6 out in the smoking gazebo with her smoking apron on and smoking with supervision from a staff member. Interview on 03/30/22 with the MDS Coordinator	F 656	F656 Develop/Implement Comprehensive Care Plan ¿ Resident #6's care plan was updated on 3/30/22 to reflect a smoking comprehensive care plan. Resident #41's care plan was updated on 3/30/22 to reflect contracture management and use of a hand roll. ¿ On 4/18/2022 the Administrator completed an audit of all care plans for smokers and residents with hand rolls/splints. On 4/20/2022 the MDS Coordinator updated all care plans of those residents found to not have a care plan for smoking or hand rolls/splints. Beginning on 4/18/2022 the MDS Coordinator will review physician orders and new admission packets to adequately develop and implement the comprehensive care plan. ¿ On 4/18/2022 the Administrator conducted an in-service with the MDS Coordinator on implementing, revising, and developing care plans. On 4/18/2022 an in-service was given by the Administrator with the Nursing Department to include all Registered Nurses (RN), Licensed Practical Nurses (LPN) on care plan development, implementation, and revision of the residents' care plans. Beginning on 4/18/2022 this training will be provided to	

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revealed she was responsible for completing the comprehensive care plans on the residents including Resident #6. The MDS Coordinator stated Resident #6 did not have a care plan that addressed smoking but said she should have had a smoking care plan. She further stated it was an oversight, but she would make sure Resident #6 had a care plan for smoking before the end of the day.

Interview on 03/30/22 with the Director of Nursing (DON) at 6:33 PM revealed Resident #6 was a supervised smoker and should have had a comprehensive care plan to address smoking. The DON stated she expected Resident #6's care plan to be updated immediately to address smoking.

2. Resident #41 was originally admitted to the facility on 11/30/11 with diagnoses which included contractures to the left and right hand.

Review of Resident #41's quarterly Minimum Data Set (MDS) dated 3/7/22 revealed the resident had severly impaired cognition and was totally dependent and required one people assist for majority of activities of daily living (ADL). The MDS further revealed Resident #41 was coded for impairment to the lower and upper extremities on both sides.

Review of Resident #41's care plan revised on 3/21/22 indicated the resident required assistance to maintain maximum function of self-sufficiency for mobility related to contractures of both hands. The goal for Resident #41 was for contractures of hands not to worsen. Interventions in place included follow recommendations as indicated and use handroll in palm of both hands. The

all new hires and agency nursing staff during orientation.

¿ The DON/Staff Development/Administrator will complete audits using the Audit Tool for Care Plan Development and Revision. This audit tool will audit 5 random residents weekly. This will be done 1-time weekly x 8 weeks then 1-time monthly x 2 months. The DON/Treatment Nurse will complete audits using the Audit Tool for Contracture Prevention/ Decrease/ Management and Use of a Device. This toll will audit all residents with a contracture to ensure adequate interventions are in place. This will be done 2-times a week x 4 weeks then one-time a month x 2 months. Results of audit will be shared with QAPI members monthly x 2 months or until a time determined by the QAPI members for sustained compliance.

¿ Alleged date of compliance is 4/23/22.

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intervention explained Resident #41's handroll could be a carrot, gauze, or wash cloth.

An observation conducted on 3/28/22 at 10:16 AM revealed Resident #41 asleep in the bed with both hands balled up towards her chest. The observation further revealed no washcloth, carrot, or gauze in the palms of Resident #41's hand.

An observation conducted on 3/28/22 at 4:05 PM revealed Resident #41 asleep in the bed with both hands balled up towards her chest. The observation further revealed no washcloth, carrot, or gauze in the palms of Resident #41's hand.

An observation conducted on 3/29/22 at 8:13 AM revealed Resident #41 awake in bed with both hands balled up with no skin marks or tears to her palms. The observation further revealed no washcloth, carrot, or gauze in the palms of Resident #41's hands.

An observation and interview were conducted on 3/29/22 at 10:30 AM with a Med Aide #1 revealed Resident #41 was awake in the bed without a handroll in the palms of her hands. The Med Aide dug through Resident #41's top dresser drawer and found two light blue hand rolls with elastic straps and placed them in Resident #41's hands with no issue. The Med Aide stated she had usually put washcloths in Resident #41's hands but had not used the handrolls in a while. It was observed Resident #41 did not have any skin tears or wounds to her hands.

An interview conducted with Nurse Aide (NA) #1 on 3/29/22 at 10:38 AM revealed NA #1 had not been provided any education or training regarding placing hand devices in Resident #41's hands

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and could not recall if the resident was care planned for interventions for the contractures. NA #1 stated he had never observed Resident #41 with any hand devices in her hands in the past year of working in the facility.

An interview conducted with NA #2 on 3/29/22 at 11:05 AM revealed they had not observed any kind of item placed in Resident #41s palm in several months. NA #2 further revealed she was educated by other nursing staff that Resident #41 had handrolls, but the resident did not always have them on because nursing staff would forget. NA #2 indicated Resident #41 tolerated the handrolls when they were placed.

An interview conducted with NA #3 on 3/29/22 at 11:28 AM revealed Resident #41 had not been observed with any item placed in Resident #41's palms since December 2021. NA #3 further revealed she had placed the handrolls on Resident #41's hands before and the resident tolerated the handrolls but felt like she might not have done them correctly. The NA stated she quit placing them on Resident #41 and reported it to a nurse she felt uncomfortable applying handrolls. NA #3 indicated facility staff were never trained how to use hand devices, so she quit applying them.

An interview conducted with the Occupational Therapist (OT) revealed since admission Resident #41 had contractures to both hands and had been recently discharged from therapy on 12/20/21. The OT further revealed it was expected for nursing staff to place the handrolls in Resident #41's hands daily to assist with the contractures and protection of the residents' palms. The OT stated Resident #41 had tolerated

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F 656	Continued From page 19 the handrolls during therapy, and no staff had reported that the resident had not tolerated them. The OT revealed after Resident #41 was discharged from therapy she had trained and educated nursing staff on the importance of hand devices being worn daily and how to apply them. The OT revealed she had evaulated Resident #41 and the residents contractures had remained the same and no injuries to the plam of the hands. An interview conducted with the Director of Nursing (DON) on 3/30/22 at 6:33 PM revealed Resident #41 had issues with contractures to both hands for several years. The DON further revealed she would expect for staff to follow interventions and follow Resident #41's care plan. It was indicated all nursing staff should had been educated and trained to follow the resident's intervention and document if Resident #41 was unable to tolerate.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657		4/23/22

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the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff interviews, and observations the facility failed to revise a fall risk care plan for 1 of 3 (Resident #41) residents reviewed for fall prevention.

The findings included:

Resident #41 was originally admitted to the facility on 11/30/11 with diagnoses which included contracture to left hand, contracture to right hand, abnormal posture, and dementia.

Review of Resident #41's care plan revised on 1/10/22 indicated the resident was at risk for falls characterized by multiple risk factors which included history of falls, impaired balance, impaired cognition, and impaired mobility. The goal for Resident #41 was to sustain from a serious injury. Interventions in place included a fall mat on floor when resident is in the bed as available or as resident will allow and keep the call light in reach.

Review of Resident #41's quarterly Minimum

F 657

F657 Care Plan Timing and Revision
¿ Resident #41's care plan was updated on 3/30/22 to reflect the risk for fall intervention. The fall mat is no longer used, and an intervention was added to keep resident bed in low position while resident is in bed.
¿ On 4/18/2022 the Administrator completed an audit of all care plans for residents with a fall risk. On 4/18/2022 the MDS coordinator did a facility sweep on all fall risk interventions to confirm they are current and being used. Beginning on 4/18/2022 the MDS Coordinator/DON began updating all care plans of those residents at risk for falls to add or delete interventions as needed, this was completed on 4/22/2022.
¿ Beginning on 4/18/2022 the MDS Coordinator/DON review 24-hour progress reports and incidents reports. On 4/18/2022 the Administrator in-serviced the MDS Coordinator/DON on development and revision and updating of

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F 657	Continued From page 21 Data Set (MDS) dated 3/7/22 revealed the resident had severely impaired cognition and was totally dependent and required one people assist for majority of activities of daily living (ADL). The MDS further revealed Resident #41 was coded for not having any falls since admission, reentry, or the prior assessment. An observation conducted on 3/28/22 at 10:16 AM revealed Resident #41 asleep in the bed with both hands balled up towards her chest. The observation further revealed the call light was not in reach of Resident #41. It was also observed no fall mat placed on the floor or in the room of Resident #41. An observation conducted on 3/28/22 at 4:05 PM revealed Resident #41 asleep in the bed with both hands balled up towards her chest. The observation further revealed the call light was not in reach of Resident #41. It was also observed no fall mat placed in the floor or in the room of resident #41. An observation conducted on 3/29/22 at 8:13 AM revealed Resident #41 awake in bed hands balled up towards her chest. The observation further revealed the call light was not in reach of Resident #41. It was also observed no fall mat placed in the floor or in the room of resident #41. An observation and interview conducted with the Treatment Nurse on 3/29/22 at 8:19 AM revealed Resident #41's call light was on the table not in reach of the resident and no fall mats in the room. The Treatment Nurse further revealed Resident #41 was not able to use a call light due to her both hands being contracted. It was indicated Resident #41 had not had any falls in the past	F 657	the care plan. On 4/18/2022 the Administrator/DON conducted an in-service with the Nursing department to include all Registered Nurses (RN), Licensed Practical Nurses (LPN) and Therapy Department to notify MDS on resident changes to ensure resident specific care plan that fits the needs of the resident. Beginning on 4/18/2022 this training will be provided to all new hires and agency nursing staff during orientation. ¿ The Director of Nursing/Staff Development/Administrator will complete audits using the Audit Tool for Care Plan Development and Revision. The tool will audit all new admits, re-entries to the facility, residents in respite, and any resident who has had a fall within that week of auditing. This will be done 1-time weekly x 8 weeks then 1-time monthly x 2 months. Results of audit will be shared with the QAPI members monthly x 2 months or until a time determined by the QAPI members for sustained compliance. ¿ Alleged date of compliance is 4/23/22.	

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F 657	Continued From page 22 year and was not in need of fall mats because Resident #41 could not turn herself in bed. The Treatment Nurse stated Residents #41's care plan interventions should have not included fall mats and a call light. An interview conducted with a Nurse Aide #2 on 3/29/22 at 11:05 AM revealed she had taken care of Resident #41 for the past year and have never seen falls mats in the resident's room. NA #2 indicated Resident #41 was unable to transfer in the bed and had never had a fall. The NA further revealed Resident #41 was unable to use a call light due to the resident having contractures so nursing staff would place it across the bedside table. An interview conducted with the MDS Coordinator on 3/30/22 at 9:51 AM revealed resident care plans were revised by assessing the resident, talk to nursing staff, and review progress notes. The MDS Coordinator further revealed Resident #41 was no longer able to use her call light due to right- and left-hand contracture and had not had any falls in a long period of time. The MDS Coordinator stated Resident #41's care plan should had been revised and the fall mats and call light should had been removed. An interview conducted with the Director of Nursing (DON) on 3/20/22 at 6:22 PM revealed Resident #41 was unable to use a call light due to contractures to both hands and had not experienced any falls in the past year. The DON further revealed Resident #41 care plan should had been revised because the resident no longer used the call light or a fall mat.	F 657		
F 677 SS=E	ADL Care Provided for Dependent Residents	F 677		4/23/22

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CFR(s): 483.24(a)(2)

§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;
This REQUIREMENT is not met as evidenced by:
Based on observations, record reviews, resident and staff interviews, the facility failed to provide showers for 2 of 6 dependent residents (Resident #6 and Resident #7) reviewed for activities of daily living (ADL).

The findings included:

1. Resident #6 was admitted to the facility on 09/03/21 and readmitted on 11/15/21. Her admitting diagnoses included end stage renal disease, chronic obstructive pulmonary disease, and diabetes.

Resident #6's quarterly Minimum Data Set (MDS) assessment dated 12/23/21 revealed she was moderately cognitively impaired, had no rejection of care behaviors and required extensive assistance of 1 staff member with bathing.

Review of Resident #6's care plan dated 01/05/22 revealed a focus of activities of daily living/personal care related to debility and cardiorespiratory conditions. Interventions included extensive assistance one person for bathing.

Review of the Main Shower Schedule indicated Resident #6 was scheduled to receive a shower on Thursdays and Sundays on the evening shift.

F 677

F677 ADL Care Provided for Dependent Residents

¿ Resident #6 agreed to and was provided a shower on 4/1/2022, Resident #7 agreed to and was provided a shower on the 3-11 shift on 3/31/2022.

¿ Beginning on 4/5/2022 the Administrator, DON, or Treatment Nurse complete daily checks on the shower log and documentation in the electronic health record to identify any missed showers. The Nursing Staff will document the resident's acceptance or refusal of the shower. The nurse will encourage the resident to take a shower or bed bath and if they still refuse the nurse will document the refusal in the resident's electronic health record.

¿ On 4/18/2022 The Administrator conducted an in-service with Nursing Staff, and Therapy Department on the activities of daily living (ADL) for showers, including offering all residents the opportunity to shower, offering a bed bath if the shower is refused, notifying the nurse if both are refused, and the nurse's responsibility for asking the resident again if they want a shower or bath, and how to document on the shower schedule and in the electronic health record. Beginning on 4/18/2022 this training will be provided to

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Resident #6's shower documentation report for February 2022 indicated showers were not documented as given on 02/03/22, 02/20/22 and 02/27/22.

Resident #6's shower documentation report for March 2022 indicated showers were not documented as given on 03/03/22, 03/06/22, 03/13/22, 03/17/22, 03/20/22, and 03/27/22.

Observation and interview with Resident #6 on 03/28/22 at 10:20 AM revealed a slight body odor was detected upon entering her room. She was dressed in her wheelchair and her hair appeared slightly matted to her head and greasy. Resident #6 stated she was supposed to get a shower on Thursday and Sunday on second shift but stated she didn't always get them because the facility did not have enough staff. Resident #6 further stated she wanted to get her showers so she would feel clean on her days she went to dialysis.

Interview with NA #3 on 03/29/22 at 11:21 AM revealed she sometimes stayed over until 11:00 PM to assist on 2nd shift. NA #3 stated there were some days they just could not get all the showers done on the evening shift due to staffing. She further stated sometimes they try to get the showers done the next day if a resident misses a shower but said they were not always able to do that.

Interview with Nurse Aide (NA) #4 on 03/29/22 at 4:43 PM revealed it was hard to get showers done on 2nd shift. NA #4 stated if there were 4 NAs on till 11:00 PM they could get showers done but when there was only 2 or 3 NAs it was impossible to get the showers done. NA #4 further stated Resident #6 liked to go out at 8:00

F 677

all new hires and agency nursing staff during orientation.

¿ Beginning on 4/18/2022 the DON/SDC/Treatment Nurse will monitor the shower schedule to ensure showers are given, bed baths offered, nurse notified if resident refused using the Audit Tool for Showers 2 x's weekly x 8 weeks then 1 time a month for 2 months. The audit will be done by interviewing the residents with a BIMS of 12 or higher and monitoring the shower schedule for all other residents. The shower schedule sheet will be reviewed 5 days a week and if a shower was not given the Administrator/DON will investigate to ensure a bed bath or an alternate day for a shower was offered. Results of audit will be shared with the QAPI members monthly x 2 months or until a time determined by the QAPI members for sustained compliance.

¿ Alleged date of compliance is 4/23/22.

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PM to smoke and by the time she was back in her room it was 9:00 PM or after and time to start the last rounds.

Interview with Nurse #1 on 03/29/22 at 2:04 PM revealed she sometimes stayed over and assisted with care on 2nd shift but stated she had not given showers. Nurse #1 stated the NAs were not always able to get all the showers done on 2nd shift due to staffing. She further stated it had been better when they were using agency NAs because they had more help in the facility.

Interview on 03/30/22 at 5:45 PM with the Director of Nursing (DON) revealed it had been a struggle finding staff to work the evening shift and she was aware there had been a problem with showers on the 2nd shift. The DON stated she had been trying to get the shower schedule so it was manageable for the staff and had revised it to stretch to seven days a week instead of 5 so there would be less showers to do each day.

2. Resident #7 was admitted to the facility on 5/13/21 with diagnoses that included multiple sclerosis (MS).

Resident #7's care plan revised on 10/14/21 indicated a focus of activities of daily living/personal care related to MS. Interventions included extensive dependence on one person for bathing.

The quarterly Minimum Data Set (MDS) assessment dated 1/7/22 indicated Resident #7 was cognitively intact, had no rejection of care behaviors and required extensive physical assistance with all activities of daily living

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including bathing.

A review of the Main Shower Schedule indicated Resident#7 was scheduled to receive a shower on Mondays and Thursdays on the evening shift.

Resident #7's shower documentation report for February 2022 indicated showers were not documented as given on 2/3/22, 2/7/22, 2/14/22, 2/21/22 and 2/24/22.

Resident #7's shower documentation report for March 2022 indicated showers were not documented as given on 3/7/22 and 3/14/22.

An observation and interview with Resident #7 on 3/28/22 at 10:25 AM revealed a slight body odor was detected upon entering Resident #7's room. Resident #7 was lying in bed, and he stated that he was supposed to get a shower on Mondays and Thursdays, but he didn't always get them because the facility did not have enough staff. Resident #7 further stated he felt dirty when he didn't get his showers at least twice a week. He said he did not receive a shower on the first two Mondays of March 2022.

An interview with Nurse Aide (NA) #4 on 3/29/22 at 4:42 PM revealed it was hard to get Resident #7's shower done because it took her 45 minutes to an hour to do it. NA #4 stated she had taken care of Resident #7 on 2/3/22 and 2/24/22 but was unable to give him his scheduled shower because they didn't have enough staff on those evenings. NA #4 stated it was hard to get everything done when there were only 2 nurse aides on the evening shift for the whole facility. NA #4 also stated she couldn't do Resident #7's shower because somebody needed to watch the

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floor and she couldn't do that if she was in the shower room with Resident #7 for an hour.

An interview with Nurse #4 on 3/30/22 at 11:22 AM revealed she came in to work part of the evening shift from 7:00 PM to 11:00 PM on 2/7/22 to work as a nurse aide and was assigned a group that included Resident #7. Nurse #4 stated she did not have time to give Resident #7 a shower on 2/7/22. All she had time to do were to provide incontinence care, pick up supper trays and assist residents to bed.

An interview with NA #5 on 3/29/22 at 8:41 PM revealed she normally worked the night shift from 11:00 PM to 7:00 AM but she had been coming in at 7:00 PM because staffing on the evening shift had been poor. NA #5 stated she didn't have time to do showers on the evening shift because they were always short-staffed. She stated that Resident #7 did not refuse to take his showers, but she didn't have time to give him one on 2/14/22 when she came in at 7:00 PM.

An interview with NA #6 on 23/29/22 at 5:03 PM revealed she had taken care of Resident #7 on 2/21/22 on the evening shift and was unable to give him a shower that day. NA #6 stated Resident #7 refused a shower when she had asked him because he wanted to take his shower at 10:00 PM. NA #6 stated she couldn't give him a shower at 10:00 PM because that was the same time she started her incontinence rounds.

An interview with NA #3 on 3/29/22 at 11:21 AM revealed she had not given Resident #7 a shower because she worked on the day shift, but she knew he got mad when he didn't get a shower and he did not refuse any of his showers.

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F 677	Continued From page 28 An interview with the Director of Nursing (DON) on 3/30/22 at 5:44 PM revealed she had written up NA #8 who no longer worked at the facility for not giving Resident #7 his showers. The DON stated NA #8 routinely worked on his hall, but she had not been giving him his showers. The DON stated she had counselled her and told her she knew Resident #7's shower was difficult to do but they still had to do it. The DON also stated they had a struggle finding staff to work on the evening shift and she was aware the facility had a problem with showers. The DON stated she had been trying to get the shower schedule manageable and feasible and had revised it to stretch to seven days of the week so there were less showers to do each day.	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.	F 688		4/23/22

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This REQUIREMENT is not met as evidenced by:

Based on observation, record review, and staff interviews the facility failed to apply a hand device for contracture management as recommended by occupational therapy (OT) for 1 of 3 (Resident #41) reviewed for range of motion.

The findings included:

Resident #41 was originally admitted to the facility on 11/30/11 with diagnoses which included contracture to the left and right hand.

Review of OT discharge summary dated 12/20/21 stated discharge recommendations to continue placement of hand rolls or carrots for contracture management daily up to 6 hours for deceased risk for further contractures and skin breakdown.

Review of progress notes from December 2021 to March 2022 revealed no documentation of Resident #41 refusing or not being able to tolerate hand devices.

Review of Resident #41's quarterly Minimum Data Set (MDS) dated 3/7/22 revealed the resident was severely / moderately impaired cognition and was totally dependent and required one people assist for majority of activities of daily living (ADL). The MDS further revealed Resident #41 was coded for impairment to the lower and upper extremities for both sides.

Review of Resident #41's care plan revised on 3/21/22 indicated the resident required assistance to maintain maximum function of self-sufficiency for mobility related to contractures of both hands. The goal for Resident #41 was for contractures of

F 688

F688 Increase/Prevent Decrease in ROM/Mobility

¿ Resident #41 was evaluated by therapy on 3/30/2022. Resident was provided handrolls for bilateral hands to prevent decrease in range of mobility and skin protection due to contractures.

¿ On 4/05/2022 and 4/15/2022 an audit was completed by MDS Nurse on all residents with hand rolls and splints for contracture management to ensure the assistive devices are being placed properly. The audit determined hand rolls / splints for contractures were in place at the time of the audits. All new therapy referrals for contracture management will be discussed and reviewed with Treatment Nurse, DON, and/or MDS Nurse.

¿ On 4/18/2022 the Administrator/DON conducted an in-service with the Nursing Staff to include all Registered Nurses (RN), Licensed Practical Nurses (LPN) and certified nursing assistants (CNA) on the proper use of hand rolls and/or braces and splints, documentation of them being placed, resident refusals, notifying the nurse, therapy, and MD of resident refusal, nurse monitoring the skin where the device is located, and updating the care plan if device is ordered or discontinued. Beginning on 4/18/2022 this training will be provided to all new hires and agency nursing staff during orientation. All residents requiring handrolls or splinting will have that listed in their care plan and care guide, the

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hands not to worsen. Interventions in place included follow recommendations as indicated and use handroll in palm of both hands. The intervention explained Resident #41's handroll could be a carrot, gauze, or wash cloth.

An observation conducted on 3/28/22 at 10:16 AM revealed Resident #41 resting with eyes closed with both hands balled up towards her chest. The observation further revealed no washcloth, carrot, or gauze in the palms of Resident #41's hands.

An observation conducted on 3/28/22 at 4:05 PM revealed Resident #41 resting with eyes closed in the bed with both hands balled up towards her chest. The observation further revealed no washcloth, carrot, or gauze in the palms of Resident #41's hands.

An observation conducted on 3/29/22 at 8:13 AM revealed Resident #41 awake in bed with both hands balled up with no skin marks or tears to her palms. The observation further revealed no washcloth, carrot, or gauze in the palms of Resident #41's hands.

An observation and interview were conducted on 3/29/22 at 10:30 AM with a Med Aide #1 revealed Resident #41 was awake in the bed without a handroll in the palms of her hands. The Med Aide dug through Resident #41's top dresser drawer and found two light blue hand rolls with elastic straps and placed them in Resident #41's hands with no issue. The Med Aide stated she had usually put washcloths in Resident #41's hands but had not used the handrolls in a while. It was observed Resident #41 did not have any skin tears or wounds to her hands.

F 688

devices were added to the MAR and the nurses will be responsible for the application and removal as well as documentation of the devices used.
¿ The Director of Nursing/Staff Development/MDS Nurse will complete audits using the Contracture Prevention/Decrease/Management and Use of Device tool on new admissions, therapy discharges, and during quarterly assessments. This will be done 2-times weekly x 4 weeks then 1-time monthly x 2 months. Results of audit will be shared with the QAPI members monthly x 2 months or until a time determined by the QAPI members for sustained compliance.
¿ Alleged date of compliance is 4/23/22.

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An interview conducted with Nurse Aide (NA) #1 on 3/29/22 at 10:38 AM revealed NA #1 had not been provided any education or training regarding placing hand devices in Resident #41's hands and could not recall if the resident was care planned for interventions for the contractures. NA #1 stated he had never observed Resident #41 with any hand devices in her hands in the past year of working in the facility.

An interview conducted with NA #2 on 3/29/22 at 11:05 AM revealed they had not observed any kind of item placed in Resident #41s palm in several months. NA #2 further revealed she was educated by a Nurse that hands rolls were supposed to be applied daily, but the resident did not always have them on because nursing staff would forget to place them on. NA #2 indicated Resident #41 tolerated the handrolls when they were placed.

An interview conducted with NA #3 on 3/29/22 at 11:28 AM revealed Resident #41 had not been observed with any item placed in Resident #41's palms since December 2021. NA #3 further revealed she had placed the handrolls on Resident #41's hands before and the resident tolerated the handrolls but felt like she might not have done them correctly. The NA stated she quit placing them on Resident #41 and reported it to a nurse she felt uncomfortable applying handrolls. NA #3 indicated facility staff were never trained how to use hand devices, so she quit applying them.

An interview conducted with the Occupational Therapist (OT) on 3/30/22 at 12:56 PM revealed since admission Resident #41 had contractures

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to both hands and had been recently discharged from therapy on 12/20/21. The OT further revealed it was expected for nursing staff to place the handrolls in Resident #41's hands daily to assist with the contractures and protection of the residents' palms. The OT indicated all nursing staff that assisted resident #41 had been educated and trained to apply hand devices. The OT stated Resident #41 had tolerated the handrolls during therapy, and no staff had revealed that the resident had not tolerated them. The OT revealed after Resident #41 was discharged from therapy she had trained and educated nursing staff on the importance of hand devices being worn daily and how to apply them. The OT revealed she had evaualted Resident #41 and the resident's contractures had remained the same and there was no skin impairment noted to the palms of the resident's hands.

An interview conducted with the facility Medical Director (MD) on 3/30/22 at 4:40 PM revealed he expected nursing staff to follow interventions and orders and to attempt placing the hand rolls on Resident #41 and document if not tolerated to help prevent injury to hands.

An interview conducted with the Director of Nursing (DON) on 3/30/22 at 6:33 PM revealed Resident #41 had issues with contracture to both hands for several years. The DON further revealed she would expect for staff to follow Resident #41's interventions. The DON indicated she thought nursing staff who had cared for Resident #41 had been educated and trained. The DON stated it was expected for all nursing staff to follow Resident #41's interventions and document if Resident #41 was unable to tolerate.

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F 696 SS=D	Prostheses CFR(s): 483.25(j) §483.25(j) Prostheses The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and record review, the facility failed to apply a residents prosthetic limb to assist with the resident's ability to ambulate for 1 of 1 resident sampled for accommodation of needs (Resident #3). The findings included: Resident # 3 was admitted to the facility on 05/22/2019 with a diagnosis of hemiplegia and left above the knee amputation. The quarterly Minimum Data Set (MDS) dated 03/11/22, noted Resident #3 to be cognitively intact. Resident #3 required extensive assistance of two staff members for transfers and ambulation. The MDS further revealed Resident #3 was coded as not using a prosthetic limb during the look back assessment period. A care plan dated 09/30/21 read in part, Resident #3 required assistance for transferring from one position to another due to left side hemiparesis and left above the knee amputation. The goal was for Resident #3 to receive the necessary physical assistance to transfer through the next	F 696	F696 Prostheses ¿ Resident #3 was seen by the Sunshine Prosthetics Company, on 4/11/2022 to be re-measured for a stump shrinker. The company will remake the shrinker and deliver it to the resident. Resident #3 will begin therapy to use the prosthetic limb on the left leg when she receives the stump shrinker. On 4/5/2022 the therapy gym was cleaned and clear of items not related to therapy. ¿ On 4/5/2022 Administrator completed a facility wide audit and identified one other resident that could potentially utilize prosthetic care. On 4/11/2022 this Resident was also seen by Sunshine Prosthetics Company and measured for stump shrinkers. ¿ On 4/18/2022 an in-service was conducted by the Administrator/DON with the nursing department to include all Registered Nurses (RN), Licensed Practical Nurses (LPN) and certified nursing assistants (CNA) on notifying therapy of a new admit with a prosthetic, notifying therapy if there are any changes with the resident, notifying therapy if the	4/23/22

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	345219	A. BUILDING ______ B. WING ______	C 03/30/2022

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MAGNOLIA LANE NURSING AND REHABILITATION CENTER	**107 MAGNOLIA DRIVE MORGANTON, NC 28655**

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F 696	Continued From page 34 review date. Interventions included encouraging the resident to be out of bed daily and use of a mechanical lift. The care plan did not include use of the resident's prosthetic limb. A care plan note dated 02/12/21 revealed Resident #3 had desired to have a prosthetic limb. Physical therapy had made contact with a prosthetics company to set up a possible evaluation. The Business office was checking to make sure the residents Medicare would cover the cost of the prosthetic limb or if Resident #3 would have to pay a out of pocket cost. A Physical Therapy (PT) progress note dated 03/17/21 revealed Resident #3 had been picked up by therapy to focus on prosthetic initial training, prosthetic management, therapeutic exercise and gait training. The note revealed Resident #3 was agreeable to the PT evaluation and treatment. A PT plan of care note revealed Resident #3 was discontinued from PT services on 06/17/21. The discharge plans were for the resident to remain in a skilled nursing facility with functional maintenance. A care plan note dated 04/29/21 revealed Resident #3 had just received a new prothesis and was working with physical therapy. An observation was conducted of Resident #3's room on 03/29/22 at 9:25 AM. The observation revealed Resident #1's prosthetic limb standing in the corner of her room. An interview conducted on 03/29/22 at 9:34 AM with Resident #3 revealed the prosthetic limb had	F 696	resident is not wearing the prosthesis correctly or refuses to wear it. Beginning on 4/18/2022 this training will be provided to all new hires and agency nursing staff during orientation. ¿ The Administrator/DON/SDC will monitor all residents with a prosthesis using the Audit Tool Prostheses Training for Residents by Therapy 1-time weekly x 4 weeks, then 1-time monthly x 2 months. The tool will be activated for all current residents and residents with a prosthesis on admission. Results of audit will be shared with the QAPI members monthly x 2 months or until a time determined by the QAPI members for sustained compliance. ¿ Alleged date of compliance is 4/23/22.	

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F 696	Continued From page 35	F 696		

been in the corner of the room unused for 6 months. She stated she had been told PT could not work with her due to the facility gym being closed because of renovations. She stated it upset her because she wanted to use her prosthetic limb and had told staff for several months.

A follow up interview was conducted on 03/30/22 at 10:53 AM with Resident #3. During the interview she stated she had stopped the Physical Therapy Manager in the hall and told her that she had told the surveyor she wanted to use her prosthetic limb. She stated the Physical Therapy Manager told her they were waiting on the gym to open back up and that they would start working with her again. She also told Resident #3 they would need to use the parallel bars working with her and they could not get to the bars to work with her at that time. She stated she was told her prosthetic limb probably wouldn't not fit because it had been so long of a time period, and they would have to have someone come a refit it for her. Resident #3 stated she wished she could have worn her prosthetic limb sooner but understood that a lot had went on in the facility with renovations and she hoped they would start working with her soon.

On 03/29/21 at 9:44 AM an interview was conducted with the Physical Therapy Manager. She stated the facility had been renovating the downstairs gym and therapy had been moved upstairs to a room in the facility. The therapy staff were also doing a lot of therapy inside the resident rooms. She stated the gym was still not open but would hopefully be open soon. The interview revealed she had worked with Resident #3 when she received her prosthetic limb in

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March of last year however during her therapy, she had hit a wall with her progress and was not wanting to get out of bed. She stated she felt like therapy had gotten as far as they could with Resident #3 using her prosthetic limb and the resident lost motivation. The interview revealed the PT Manager told Resident #3 she was discontinuing her therapy until she showed motivation such as getting out of the bed to her wheelchair daily. She stated she had known Resident #3 wanted to use her prosthetic limb and had noticed she was getting up daily as asked during the last several months. The PT Manager stated Resident #3 had stopped her in the hallway and told her she told the surveyor she wanted to use her prosthetic limb. The PT Manager said she would have to call a prosthetist to do a fitting with her because the limb would need adjustments due to the time period it had been since the resident had worn the prosthetic limb.

On 03/30/22 at 10:35 AM a follow up interview was conducted with the Physical Therapy Manager. She stated she had called a prosthetist to come do a fitting with Resident #3 and therapy planned on getting her back into their program. She stated she knew the resident was mobilizing up and down the hallway a lot and she thought the resident was ready for PT services. The interview revealed the lapse in Resident #3's therapy was mainly due to the facility renovations and access to the gym. She stated they had taken a few residents down to use the gym before the facility started using the gym as storage for boxes of files but that it had never been up and fully functional. The interview revealed that normally Resident #3 would not have had to wait 9 months for therapy to pick her back up but due

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to COVID-19 and the renovations her treatment kept getting post poned. She stated with Resident #3 she really needed access to the gym and parallel bars.

On 03/29/22 at 10:03 AM an interview was conducted with the Administrator. She stated the gym was recently renovated and the facility had experienced an issue with storage containers. She stated a lot of boxes were moved into the newly renovated gym for storage about two and a half weeks prior. The interview revealed the gym had only been used for storage for the two and a half weeks but prior to that was accessible for therapy staff to use and get to the parallel bars. She stated if therapy had wanted to work with Resident #3, they could have used the parallel bars and could still use the parallel bars if they moved the boxes and made room.

On 03/29/22 at 10:31 AM an interview was conducted with the Director of Nursing (DON). She stated she had been in the facility since the end of October, so she wasn't in the building for the time period Resident #3 was using her prosthetic limb. The DON stated Resident #3 usually got up in the mornings and stayed up in her wheelchair during the day until after supper she wanted assistance getting in bed. The interview revealed she hadn't known Resident #3 to not want to get out of the bed during the day. She stated PT should have worked with the resident prior to now and Resident #3 shouldn't have had to of waited 9 months for therapy services. The DON stated the resident's prosthetic limb would probably not even fit now and they would have to call someone to come adjust it. The interview revealed therapy did have access to the parallel bars in the gym.

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F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to 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). §483.35(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. §483.35(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. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, and staff interviews, the facility failed to provide sufficient nursing staff to provide showers as scheduled for 2 residents and failed to honor residents scheduled smoking times for 3 residents who required supervised smoking. This affected 5 of 9 residents reviewed for sufficient nursing staff.	F 725	F725 Sufficient Nursing Staff ¿ Residents #31, #3, and #7 were given the opportunity for a smoke break on 3/29/22 with smoking opportunities to be provided four times each day. Resident #7 was provided a shower on 3/31/22. Resident #6 was provided a shower on 4/1/2022.	4/23/22

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F 725	Continued From page 39 The findings included: This tag is cross referred to: F561: Based on record reviews, resident, and staff interviews, the facility failed to honor smoking times and residents choice to smoke as scheduled every day for 3 of 4 residents (Resident #31, #3 and #7) who were identified as supervised smokers. F677: Based on record review, observation and resident and staff interviews, the facility failed to provide showers as scheduled for 2 of 5 sampled residents (Resident #6 and Resident #7) who were dependent on staff for activities of daily living. On 03/29/22 at 10:49 AM an interview was conducted with Nurse Aide #2. During the interview she stated she wasnt able to get showers completed due to staffing. She said on a normal basis for first shift they sometimes only have 3 Nurse Aides for the entire building. She stated the residents who smoked complained that there was not enough staff to take them out to the 8:00 PM smoking time. She stated she refused to take the smokers outside because she had to complete patient care first. An interview with the Director of Nursing (DON) on 3/30/22 at 11:22 AM revealed she had reached out to an agency company about hiring more Nurse Aides. She stated they were unable to get agency staffing because the agency counldnt provide anyone and they were told it would be two weeks before one person could come.	F 725	¿ All residents have the potential to be affected by the deficient practice. The facility currently utilizes one staffing agency to assist in adequately staffing the building. ¿ Beginning on 4/5/2022 the Administrator, Director of Nursing, and Scheduler began daily staffing reviews to ensure adequate staffing needs are being met each day. In the event that staffing is deemed inadequate, the DON and Scheduler begin reaching out to staff to cover the shifts. If they are unable to find coverage DON and Administrator are notified for support and guidance, phone numbers for both are posted at each nurse station and on assignment sheets, this process is used every day of the week and the weekends, evenings, and holidays. Beginning 4/5/2022 the Administrator, Director of Nursing, or Treatment Nurse will review the schedules for showers and smoke breaks to ensure staff are available and services provided. On 4/18/2022 the Administrator conducted in-service training with staff related to ADL care (showers) including that the RN/LPN and CNAs. Effective 4/21/2022 the facility hired 5 new staff members under the CNA Waiver program that will augment the current staff. On 4/18/2022 the Administrator in-serviced the staff on the four smoking times. The DON, Administrator or Scheduler will review the staffing schedule each morning and ensure a staff member is assigned to accommodate residents for each smoking time throughout the day. Beginning on 4/18/2022 this training will be provided to	

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F 725	Continued From page 40	F 725	all new hires and agency nursing staff during orientation. ¿ Beginning 4/18/2022 the DON will review the smoking log the following day to ensure residents had four opportunities for a smoke break. Beginning 4/18/2022 the DON/Administrator will complete audits using the Staff Schedule tool. The DON and/or Administrator will review and sign the schedule daily and will review weekend schedules on Friday. This will be done 5-times weekly x 8 weeks. Results of audit will be shared with the QAPI members monthly x 2 months or until a time determined by the QAPI members for sustained compliance. ¿ Alleged date of compliance is 4/23/2022.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately	F 761		4/23/22

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F 761	Continued From page 41 locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to date an opened multi-dose vial and discard expired multi-dose vials in 1 of 2 medication rooms (Main hall medication room) and separate topicals from oral medications in 1 of 2 medication carts (Main hall medication cart). The findings included: 1. An observation of the Main hall medication room on 3/30/22 at 11:59 AM with Nurse #2 revealed an opened and undated multi-dose vial of tuberculin purified protein derivative (PPD) which was available for use. There were also 2 opened vials of influenza vaccine dated as having been opened on 11/19/21 and 12/10/21 which were also available for use. An interview with Nurse #2 on 3/30/22 at 12:12 PM revealed the opened vial of tuberculin PPD should have been dated when it was opened because it would expire 30 days after it was opened. Nurse #2 stated that the 2 vials of influenza vaccine should have been discarded because multi-dose vials expired after 28 days of being opened. 2. An observation of the Main hall medication	F 761	F761 Label/Store Drugs and Biologicals ¿ On 3/31/2022 all opened medications were dated, and all expired medications were discarded. A full sweep of the medication rooms was performed on 3/31/2022 with all expired medications discarded. A full sweep of all medication and treatment carts was performed on 3/31/2022 with all proper medications stored, labeled, and expired medications discarded. ¿ A full facility audit was conducted on 4/04/2022 by the DON and all medications in all of the medication rooms and medication carts, and treatment carts were labeled appropriately, and no medications were found expired. ¿ On 4/19/2022 an in-service was conducted with the nursing department to include all Registered Nurses (RN) and Licensed Practical Nurses (LPN) on proper labeling of opened medications, proper discarding of expired medications, and proper storage of treatment medications. Beginning on 4/18/2022 this training will be provided to all new hires and agency nursing staff during orientation. ¿ The Director of Nursing/Staff	

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F 761	Continued From page 42 cart on 3/30/22 at 12:14 PM with Nurse #2 revealed two tubes of Clotrimazole cream that belonged to Resident #18 were stored right next to his oral medications. An interview with Nurse #2 on 3/30/22 at 12:24 PM revealed Resident #18's Clotrimazole cream should have been stored in the treatment cart because the treatment nurse was responsible for administering it to the resident. Nurse #2 stated it must have been placed accidentally in the medication cart instead of the treatment cart. An interview with the Treatment Nurse on 3/30/22 at 3:00 PM revealed Resident #18 did not have an order for Clotrimazole cream and stated that his family might have brought it in with him when he was admitted to the facility. A nurse probably found it in his room and placed it in the medication cart. An interview with the Director of Nursing (DON) on 3/30/22 at 5:44 PM revealed opened multi-dose vials usually expired within 28 days or 30 days so they should be dated when opened and discarded after either 28 days or 30 days. The DON stated the expiration dates were posted in the medication room. She also stated that Resident #18's Clotrimazole cream came from hospice, and she thought his family member might have given it to the nurse and wanted it re-ordered but it should be stored in the treatment cart and away from oral medications. The DON stated all nurses were responsible for checking the medications in the medication cart while the administrative nurses and night shift nurses were assigned to check the medication room at least once a month.	F 761	Development/Administrator will complete audits using the Expired Medications, opened medications labeled and medication storage Audit Tool. In addition to the audit tool, beginning 4/18/2022 the facility has assigned and in-serviced the night shift nurses to monitor the medication rooms and cart for expired, opened and properly labeled medications weekly and document on Weekly Medication Audit sheet for their respective hall. This will be done 1-time weekly x 8 weeks then 1-time monthly x 2 months. Results of audit will be shared with the QAPI members monthly x 2 months or until a time determined by the QAPI members for sustained compliance. ¿ Alleged date of compliance is 4/23/22.	