STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB	1028 BLAIR STREET THOMASVILLE, NC 27360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 7/17/23 through 7/20/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #UZ4K11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 7/17/23 through 7/20/23. Event ID# UZ4K11. The following intakes were investigated NC00194647, NC00194804, NC00194925, NC00194994, NC00195122. NC00196534, NC00197799, NC00198163, NC00198525, NC00199086, NC00199663, NC00201067, NC00201389, NC00203022, NC00203421, NC00204005, NC00204274, NC00204445. 7 of the 59 complaint allegations resulted in deficiency.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews of staff and a resident, the facility failed to provide a dependent resident a wheelchair to accommodate her size and inability to sit up. The resident was unable to get out of bed unless the staff would borrow a wheelchair from another	F 558	F558 1. Resident #93 has own wheelchair with pressure reduction cushion as of August 7, 2023. 2. An audit was completed on August 7,	8/17/23

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

Electronically Signed | 08/09/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB	1028 BLAIR STREET THOMASVILLE, NC 27360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 1 resident with the same accommodation needs (Resident #93) for 1 of 2 residents reviewed for accommodation of needs. Findings included: Resident #93 was admitted to the facility on 7/21/21 with the diagnosis of progressive neurological disease. Resident #93's discharge with return anticipated Minimum Data Set dated 4/16/23 documented she had an intact cognition. The resident required total dependence for bathing, transfer, and mobility. Her diagnosis was progressive neurological disease. Resident #93's care plan dated 7/20/21 had a focus for identified activity of daily living self-care deficit. The intervention was to discuss with the resident or family any loss of independence. On 7/17/23 at 10:10 am Resident #93 was observed to be sitting in her bed. There were no wheelchairs in the room that would accommodate her size and need for support while sitting. The resident was concurrently interviewed. The resident stated that she had been without a wheelchair for over a month and was not able to get out of bed unless another resident's wheelchair that fit her and could support her was borrowed since about 4/23/23. A new wheelchair was delivered yesterday but had no pressure reduction cushion so the wheelchair could not be used until the cushion was obtained. The resident stated she was informed by Physical Therapy there were not enough large wheelchairs for all the residents in the building. Resident #93 stated she had not gotten out of bed for over a	F 558	2023, by the Administrator or designee of the current residents to ensure all wheelchair dependent residents have a wheelchair and pressure reduction cushion. 3. The Therapy Director received in-service on ordering DME equipment that included the ordering process and ensuring that the facility has an accurate number of wheelchairs on August 7, 2023. 4. The Administrator or designee will complete audits of at least 8 residents weekly for 4 weeks and monthly for 2 months to ensure resident has a wheelchair with pressure reduction cushion. 5. The Administrator or designee will report findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting for at least 3 months for review to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB	1028 BLAIR STREET THOMASVILLE, NC 27360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 2 week, and wanted to visit her family. On 7/1723 at 12:15 pm an interview was conducted with the Therapy Manager. She stated that there were not enough bariatric and supportive wheelchairs (when a resident cannot sit up on their own) for all residents who required the support. She ordered wheelchairs when the corporate office provided the funding and approval. Resident #93's wheelchair funding was approved about 2 weeks ago and a wheelchair was ordered. She stated that Resident #93 had been without a wheelchair that fit her for about a month. When a resident was discharged, their wheelchair would be reassigned to another resident. A bariatric wheelchair was ordered about 2 weeks ago and had arrived yesterday. The pressure reduction cushion had not arrived, and the wheelchair cannot be used until the cushion was available. The resident had a sacral pressure ulcer. She stated the residents' shared wheelchairs so they can get out of bed and sometimes there were not enough to go around, and residents would remain in bed. On 7/20/23 at 11:30 am an interview was conducted with the Administrator. The Administrator stated he was not aware Resident #93 required a specialty wheelchair and that one was not available. He stated that there was funding for wheelchairs, and one should have been ordered when first identified. The Administrator further stated he was not aware there were not enough bariatric wheelchairs that provide sitting support for each resident that required one.	F 558		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v)	F 582		8/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB	1028 BLAIR STREET THOMASVILLE, NC 27360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 3	F 582		

§483.10(g)(17) The facility must--
(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-
(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;
(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB	1028 BLAIR STREET THOMASVILLE, NC 27360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 4 deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review, the facility failed to provide a CMS-10055 (Centers for Medicare and Medicaid Services) Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) prior to discharge from Medicare part A services to 2 of 3 residents (Resident #36 and Resident # 29) reviewed for SNF Beneficiary Protection Notification Review. Findings included: a. Resident #36 was admitted to the facility on 3/14/23. Medicare part A services began on the date of admission. The medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was signed by Resident #36 on 4/4/23. The notice indicated that Medicare coverage for skilled services was to end 4/4/23. Resident #36 remained in the facility when Medicare coverage ended and had not exhausted the Medicare benefit.	F 582	1. Residents #36 & #29 were given CMS-10055 Skilled Nursing Facility Advance Beneficiary Notice on August 7, 2023. 2. An audit was completed on August 7, 2023, by the Administrator or designee of the discharged Medicare A residents to ensure all received ABN notices. 3. The Social Worker and Business Office Manger were in serviced by August 7, 2023, by the Administrator related to ensuring that all residents who end Medicare Part A stay must receive the ABN notice 2 days before the Medicare part A stay is complete. 4. The Administrator or his designee will complete audits of all residents who end a Medicare Part A stay weekly for 4 weeks and monthly for 2 months to ensure resident received the ABN notice 2 days prior to discharge.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB	1028 BLAIR STREET THOMASVILLE, NC 27360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 5 The medical record further revealed a CMS-10055 SNF ABN was not provided to the resident or resident representative on 4/4/23. b. Resident #29 was admitted to the facility on 2/6/23. Medicare part A services began on the date of admission. The medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was signed by Resident #29 on 3/20/23. The notice indicated that Medicare coverage for skilled services was to end on 3/20/23. Resident #29 remained in the facility when Medicare coverage ended and had not exhausted the Medicare benefit. The medical record further revealed that a CMS-10055 SNF ABN was not provided to the resident or resident representative on 3/20/23. An interview was conducted with the Social Worker on 7/20/23 at 11:24 AM. She shared staff (Social Work, Business Office Manager, Therapy Director, and Minimum Data Set Nurse) met weekly and discussed each resident who received services under Medicare part A. She explained the team discussed the anticipated last covered day of Medicare services and she completed the NOMNC form but was not aware that she was responsible for issuing the SNF ABN form and had not issued this form since she began her position at the facility in April of 2023. During a telephone interview with the former Social Worker on 7/20/23 at 11:26 AM and she revealed that she was not employed at the facility after November of 2022.	F 582	5. The Administrator or designee will report findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting for at least 3 months for review to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB	1028 BLAIR STREET THOMASVILLE, NC 27360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 6 An interview was conducted with the Billing Office Manager on 7/20/23 at 11:28 AM and she revealed that she was responsible for submitting the NOMNC forms when there was not a social worker employed but was not aware of the SNF ABN form. The Administrator was interviewed on 7/20/23 at 11:33 AM and he revealed that it was the social worker's responsibility to issue the NOMNC and SNF ABN forms as applicable and was not aware that the SNF ABN forms were not provided to the resident and/or resident representatives.	F 582		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		8/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB	1028 BLAIR STREET THOMASVILLE, NC 27360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 7 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, and resident and staff interviews, the facility failed to repair the walls in the resident's room after under-sink cabinets were removed leaving holes in the wall and no floor tile in two residents rooms (rooms 222 and 217) and failed to maintain the wall behind a bed in good repair (room 218). The deficient practice was observed on 1 of 2 halls (200 hall). Findings included: a. On 7/17/23 at 11:50 am an observation and interview of was done of Resident #93 in Room 222 while sitting up in her bed. The wall under the sink was damaged/missing the plaster and paint and floor tile was missing. There were two 2 inch holes in the wall next to the bed. Resident #93 stated the under-sink cabinet was removed for resident handicapped access months ago and the wall and floor were not repaired. She stated	F 584	1. Room 222 and 217 floor tile was replaced on August 8, 2023. Room 218 wall behind bed was repaired on August 8, 2023. 2. An audit was completed on August 7, 2023, by the Administrator or designee of the current resident rooms on 200 hall to identify any wall repair and missing floor tile. All identified areas will be repaired by August 17, 2023. 3. The Management team (includes DON, ADON, Business office Manager, Admission Coordinator, Therapy Director, Central Supply Coordinator, Social Worker, Dietary Manager, Activities Director, Housekeeping Manager, Maintenance Director, Medical Records, MDS Nurse, Staffing Coordinator, and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB	1028 BLAIR STREET THOMASVILLE, NC 27360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 8 this was disappointing to the resident "they have left the hole in the wall for months and there was no storage. The hole next to the bed was fixed." The resident stated she would like the wall and floor to be fixed because it was her home. An interview was conducted on 7/18/23 at 11:45 am with the Maintenance Director. He stated the facility was required to provide a handicapped sink, so the under-sink cabinet was removed in all resident's rooms. He stated the facility was not spending the money for cement plaster to fix the walls. Due to the age and neglect of the plaster, it needed to be completely replaced. The plaster breaks easily when bumped with furniture or wheelchairs. There was constantly damage to the walls and all the walls below the sink where the cabinets were removed had not been repaired. b. During the tour of the residents' rooms on the 200 hall on 7/17/23 at 11:51 a.m., there were missing sections of floor tile and the baseboard observed beneath the handwashing sink in room 217. A second observation of room 217 on 7/20/23 at 9:50 a.m. revealed the floor and baseboard beneath the sink continued to be in disrepair. An interview with the Maintenance Director on 7/20/23 at 9:51 a.m., revealed floor tile was ordered to repair the area beneath the sink in room 217 on 4/17/23, but at the time of this interview had not been received. c. On 7/17/23 at 12:49 p.m., the wall behind the headboard of bed A in room 218 had multiple large, scratched marks with torn plaster.	F 584	Wound Care Nurses) was in serviced by August 8, 2023, by the Administrator related to how to place a work order. The Maintenance Director was educated on the procedure on what to do when he has a need and/or needs supplies how to reach out to Administration for assistance by August 9, 2023. 4. The Administrator or his designee will complete audits of 8 residents 4 weeks and monthly for 2 months to ensure resident rooms are have floor tile and are not in need of any wall repair. 5. The Administrator or designee will report findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting for at least 3 months for review to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB	1028 BLAIR STREET THOMASVILLE, NC 27360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 9	F 584		

During a second observation of room 218 on 7/20/23 at 9:42 a.m. accompanied by the Maintenance Director, the wall behind the headboard of bed A continued to be badly damaged.

On 7/20/23 at 9:43 a.m., the Maintenance Director stated that he was unaware of the damaged wall in room 218. He indicated he had not received a work order from the staff concerning the wall in room 218. He revealed he placed instructions on how to place work order requests for maintenance in the computer for staff and provided instructions to new hires. The Maintenance Director stated he frequently repaired the walls in residents' rooms when observed during his room audits due to nursing assistants pushing the beds against the walls and raising or lowering the heads of the beds. He indicated the heads of the beds should be at least six inches from the walls. The Maintenance Director revealed he had reported this issue to the Administrator.

On 7/20/23 at 11:30 am an interview was conducted with the Administrator. He stated that all the under-sink cabinets were removed from the resident's room to provide handicapped access. Because the sinks started to fall down after cabinet removal, the sinks were repaired first, and the walls were not fixed, and tile floor was not replaced. He stated that the wall damage and missing plaster dated back to the previous recertification survey. During COVID, rooms were empty, and walls were repaired while empty. The Administrator provided a purchase order form dated 7/19/23 for 24 square feet of tile that had not been approved by corporate which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB	1028 BLAIR STREET THOMASVILLE, NC 27360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 10 would cover approximately 3 bathroom floors.	F 584		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review, the facility failed to complete a significant change Minimum Data Set (MDS) assessment within 14 days after the facility determined a significant change occurred for 1 of 4 residents (Resident #59) reviewed for significant change MDS assessments. Findings included: Resident #59 was admitted to the facility on 5/6/21. Diagnosis included, in part, benign prostatic hyperplasia with urinary tract symptoms. The significant change MDS assessment with an assessment reference date (ARD) of 4/28/23 was reviewed and revealed the assessment was signed as completed on 5/16/23, 18 days after the determination that a significant change had	F 637	1. Resident #59 significant change MDS was late. 2. An audit was completed on August 7, 2023, by the Administrator or designee of the current resident to ensure all MDS submissions were not late. The audit revealed that no other significant change MDS needed submission. 3. The MDS nurse, Social Worker, Dietary Manager, Activities Director, and Therapy Director was in serviced by August 7, 2023, by the Administrator on the importance of completing MDS submissions on time and within the required timeframe. Magnolia Gardens will discuss in morning clinical meeting a review of any significant changes to	8/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB	1028 BLAIR STREET THOMASVILLE, NC 27360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 637	Continued From page 11 occurred. Attempts to interview the former MDS Nurse by telephone were unsuccessful. During an interview with the Administrator on 7/19/23 at 3:32 PM, he acknowledged over the past several months MDS assessments had been late. He said the facility had tried some different options to help get caught up on the MDS assessments, which included the hiring of a part time/as needed MDS Nurse who assisted the full time MDS Nurse. The Administrator added the facility recently made a personnel change in the MDS department and there was a new MDS Nurse who had gotten MDS assessments caught up and current.	F 637	residents that require a Significant change MDS submission. 4. The Administrator or his designee will complete audits of 8 residents 4 weeks and monthly for 2 months to ensure resident MDS for significant change were submitted on time. 5. The Administrator or designee will report findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting for at least 3 months for review to ensure compliance.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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	F 656		8/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB	1028 BLAIR STREET THOMASVILLE, NC 27360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 12 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 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to develop a care plan that addressed the use of a urinary catheter for 1 of 3 residents (Resident #59) reviewed for urinary catheters. Findings included: Resident #59 was admitted to the facility on 5/6/21. Diagnosis included, in part, benign prostatic hyperplasia with urinary tract symptoms.	F 656	1. Resident #59 care plan was updated on July 19, 2023. 2. An audit was completed on August 7, 2023, by the Administrator or designee of the current resident with urinary catheters have a care plan for the urinary catheter. No other resident was identified to need a care plan for having a urinary catheter. The facility will review all resident with new catheter to ensure they are care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB	1028 BLAIR STREET THOMASVILLE, NC 27360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 13 The significant change Minimum Data Set (MDS) assessment dated 4/28/23 revealed Resident #59 was cognitively intact and had an indwelling urinary catheter. A Care Area Assessment (CAA) was completed by the former MDS Nurse on 5/17/23 for indwelling urinary catheter. The CAA indicated a care plan would be developed with approaches to avoid complications from urinary tract infections, minimize the risk for developing pressure injuries and ensuring the resident's needs were met. The comprehensive care plan, updated 5/25/23, was reviewed and did not include a care plan that addressed the use of a urinary catheter. Attempts to interview the former MDS Nurse by telephone were unsuccessful. On 7/19/23 at 3:47 PM, an interview was conducted with MDS Nurse #1. She was new to the facility (since 6/1/23) and said Resident #59's care plan should have included a focus area for urinary catheter. She explained the care plan should have included information about monitoring for signs/symptoms of infection, observing for kinks in the tubing and instructions for emptying the collection bag. During an interview with the Administrator on 7/19/23 at 3:32 PM, he shared the facility had recently made a personnel change in the MDS department. He added a care plan should have been developed to address the use of an indwelling urinary catheter for Resident #59.	F 656	planned in the morning clinical meeting. 3. The MDS nurse was in serviced by August 7, 2023, by the Administrator that all resident with a urinary catheter must have a care plan for urinary catheter. 4. The Administrator or designee will complete audits of residents with a urinary catheter for 4 weeks and monthly for 2 months to ensure resident has a care plan for urinary catherter. 5. The Administrator or designee will report findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting for at least 3 months for review to ensure compliance.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI	F 690		8/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB	1028 BLAIR STREET THOMASVILLE, NC 27360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 14 CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff	F 690	1. Resident #59 catheter bag was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB	1028 BLAIR STREET THOMASVILLE, NC 27360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 15 interviews and medical record review, the facility failed to keep a urinary catheter bag from touching the floor to reduce the risk of infection or injury for 1 of 3 residents (Resident #59) reviewed for indwelling urinary catheters. Findings included: Resident #59 was admitted to the facility on 5/6/21. Diagnosis included, in part, benign prostatic hyperplasia with urinary tract symptoms. The significant change Minimum Data Set assessment dated 4/28/23 revealed Resident #59 was cognitively intact and had an indwelling urinary catheter. The comprehensive care plan, updated 5/25/23, was reviewed and did not include a care plan that addressed the use of a urinary catheter. On 7/17/23 at 11:51 AM and 7/19/23 at 12:57 PM, observations were made of Resident #59. He was in bed and the bed was in the lowest position. The catheter collection bag was hung on the lowest bar of the bed and half of the bag touched the floor. An interview was conducted with Resident #59 on 7/19/23 at 2:34 PM. He shared staff members came in throughout the day and emptied the catheter collection bag. During the interview, Resident #59's bed was in the lowest position and the collection bag touched the floor. Nursing Assistant (NA) #1 was interviewed on 7/19/23 at 2:40 PM. He stated he typically worked second shift (3:00 PM-11:00 PM). He explained he emptied the catheter collection bag	F 690	adjusted so it will not touch floor on July 19, 2023. 2. An audit was completed on August 7, 2023, by the Administrator or designee of the current resident with urinary catheters to ensure they are not touching the floor. Audit revealed that no other residents catheter bag was touching the floor. 3. The Nurse Aides, Housekeepers, Maintenance personnel, and nurses were in serviced by August 7, 2023, by the Administrator or designee that all resident with a urinary catheter bag that the bag may not touch the floor. Systemic change to prevent from happening again is that housekeepers and maintenance personnel have been trained to look for catheter bags not being placed on floor. 4. The Administrator or designee will complete audits of residents with a urinary catheter for 4 weeks and monthly for 2 months to ensure resident catheter bag is not touching the floor. 5. The Administrator or designee will report findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting for at least 3 months for review to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB	1028 BLAIR STREET THOMASVILLE, NC 27360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 16 when he worked with Resident #59 and said the collection bag should hang below the level of the bladder and should not have touched the floor. An observation of Resident #59's catheter collection bag and interviews with NA #2 and the Assistant Director of Nursing (ADON) were completed on 7/19/23 at 2:43 PM. The resident was in bed. The bed was in the lowest position and the collection bag touched the floor. During an interview with NA #2, she verified she worked with Resident #59 on 7/17/23 and 7/19/23 during the first shift (7:00 AM-3:00 PM). She explained she typically emptied the collection bag in the morning and again at the end of her shift (around 2:45 PM). She stated the collection bag should be hung below the level of the resident's bladder and not come in contact with the floor. She added Resident #59's bed was in the lowest position and she hung the collection bag on the lowest bar of the bed which caused the bag to touch the floor. The ADON said if the collection bag was placed on the upper bar of the bed, it was still below the level of the resident's bladder and even when the bed was in the lowest position, the bag wouldn't come in contact with the floor.	F 690		
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State	F 808		8/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB	1028 BLAIR STREET THOMASVILLE, NC 27360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 808	Continued From page 17 law. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, and staff interviews the facility failed have a physician order for a therapeutic diet per the Speech Therapist's evaluation for 1 of 5 residents (Resident #71) reviewed for nutrition. Findings included: Resident #71 was initially admitted to the facility on 2/2/22 and re-admitted on 1/25/23 with diagnoses which included: ESRD (end-stage renal disease), diabetes mellitus, and dysphagia. The most recent minimum data set dated 6/2/23 indicated Resident #71 was cognitively intact, was independent with eating, required a mechanically altered diet, received dialysis services and speech therapy. The care plan dated 1/14/23 revealed Resident #71 had a potential nutritional problem related to ESRD and pureed renal diet with nectar thickened liquids. Interventions included: RD (Registered Dietitian) to evaluate and make diet change recommendations, when needed; provide and serve diet as ordered, Monitor intake and record every meal. The physician's order dated 6/29/23 indicated Resident #71 was to receive a diet of pureed texture (double portions) and nectar thickened fluids, related to ESRD, dependence on renal dialysis, and dysphagia. The resident was ordered a 1000 milliliter fluid restriction. The resident was cleared by speech therapy for soft sandwiches. The diet order also included the	F 808	1. Resident #71 diet order was corrected on July 19, 2023. 2. An audit was completed on August 7, 2023, by the Administrator or designee of the current resident to ensure diet order matches tray card. 3. The Speech Language Pathologist was in serviced by August 7, 2023, by the Administrator or designee that all changes to a resident diet the order must be placed into electronic charting system before diet communication form is submitted to the Dietary Department. 4. The Administrator or designee will complete audits of 8 residents for 4 weeks and monthly for 2 months to ensure resident diet order matches residents tray card. 5. The Administrator or designee will report findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting for at least 3 months for review to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB	1028 BLAIR STREET THOMASVILLE, NC 27360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 808	Continued From page 18	F 808		

resident was not to receive salt packets, soups, fried foods, bananas, tomatoes, potatoes, oranges, juice, and citrus.

During a dining observation on 7/17/23 at 1:30 p.m., Resident #71 received a meal of mechanical soft consistency which included ground pot roast, egg noodles, peas, dinner roll, and a brownie. The meal card located on the resident's meal tray from the dietary department indicated the resident was to receive a meal of mechanical soft consistency with double portion entrée.

An interview was conducted on 7/18/23 at 2:55 p.m. with the facility's Registered Dietician (RD). The RD revealed that after observing this Surveyor sitting with Resident #71 during the lunch meal service on 7/16/23 and noticed the resident was consuming a meal of mechanical soft texture. The RD stated that she reviewed the physician's orders which did not indicate the resident's diet was changed from pureed texture to mechanical soft texture. She revealed that earlier this day she was informed by the Speech Therapist (ST) that she upgraded the resident's diet from pureed to mechanical soft on 7/12/23 and provided a diet slip to the dietary department before the physician's order was completed. The RD revealed she in-serviced the ST on 7/18/23 concerning not providing a diet change slip to dietary until a signed physician's order of change was received and in place.

During an interview on 7/19/23 at 10:35 a.m., the ST indicated Resident #71 received speech therapy services due to staff's concerns with meal consistency as evidenced by the resident's coughing while eating. On 5/24/23 the ST began

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB	1028 BLAIR STREET THOMASVILLE, NC 27360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 808	Continued From page 19 working with the resident for safe trials while eating. The ST acknowledged she submitted a diet communication form to dietary to upgrade Resident #71's pureed soft diet to mechanical soft with ground meats on 7/12/23. She concluded she thought she had also placed the order in the electronic record prior to submitting the change to dietary.	F 808		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators,	F 867		8/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB	1028 BLAIR STREET THOMASVILLE, NC 27360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 20	F 867		

including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB	1028 BLAIR STREET THOMASVILLE, NC 27360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 21	F 867		

consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB	1028 BLAIR STREET THOMASVILLE, NC 27360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 22 (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification surveys completed on 9/1/22 and 4/22/21. This was for 4 deficiencies that were cited in the areas of Safe/Clean/Comfortable/Homelike Environment (F584), Comprehensive Assessment After Significant Change (F637) which were cited on 9/1/22 and recited on the current recertification and complaint survey 7/20/23. Develop/Implement Comprehensive Care Plan (F656) which was cited on 9/1/22, 4/22/21 and recited on the current recertification and complaint survey 7/20/23. Bowel/Bladder Incontinence, Catheter, UTI (F690) cited on 4/22/21 and recited on the current recertification and complaint survey 7/20/23. The continued failure of the facility during three federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program (QA). The findings included: This citation is cross referred to: F584: Based on observations, and resident and staff interviews, the facility failed to repair the walls in the resident's room after under-sink cabinets were removed leaving holes in the wall	F 867	1. The Quality Assurance Committee met and reviewed the purpose and function of the Quality Assurance Performance Improvement (QAPI) Committee as well as reviewed the on-going compliance issues regarding F584, F637, F656, and F690 on August 9, 2023. 2. Current residents are potentially affected by this deficiency. 3. The Regional Nurse Consultant educated the Administrator and Director of Nursing on the appropriate functioning on the QAPI Committee and the purpose of the Committee to include identify issues and correct repeat deficiencies related to F584, F637, F656, and F690 on August 9, 2023. On August 9, 2023, the Administrator educated the QAPI committee members consisting of, the Medical Director, Administrator, Director of Nursing, Unit Support Nurse, Medical Records, Business Office Manager, Minimum Data Set (MDS) Nurse, Wound Nurse, Activities Director, Director of Rehabilitation, Dietary Manager, and Pharmacy consultant at (minimum quarterly), on a weekly QA review of audit findings for compliance and/or revision needed. In addition to weekly QA meetings, the QAPI committee will continue to meet monthly. Quality Assurance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB	1028 BLAIR STREET THOMASVILLE, NC 27360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 23 and no floor tile in two residents rooms (rooms 222 and 217) and failed to maintain the wall behind a bed in good repair (room 218). The deficient practice was observed on 1 of 2 halls (200 hall). During the recertification survey on 9/1/22, the facility failed to maintain a clean and homelike environment by not ensuring Room #222 had a working toilet for at least 3 days during the survey, not ensuring a clean resident room (Room 117A) and failed to label and cover urinals for 3 residents use in a shared bathroom (Rooms 114 and 115) for 3 of 47 rooms on 2 of 2 halls reviewed for a clean, comfortable, and homelike environment. F637: Based on staff interviews and medical record review, the facility failed to complete a significant change Minimum Data Set (MDS) assessment within 14 days after the facility determined a significant change occurred for 1 of 4 residents (Resident #59) reviewed for significant change MDS assessments. During the recertification survey on 9/1/22, the facility failed to complete a significant change assessment for 1 of 1 sampled resident reviewed for rehabilitation services. F656: Based on observation, staff interviews and record review, the facility failed to develop a care plan that addressed the use of a urinary catheter for 1 of 3 residents (Resident #59) reviewed for urinary catheters. During the recertification survey on 9/1/22, the facility failed to develop comprehensive care plans for 1 of 5 sampled residents reviewed for	F 867	4. The QAPI committee will continue to meet monthly to identify issues related to quality assessment and assurance activities as needed and will develop and implement appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to repeat deficiencies. The monitoring procedure to ensure the plan of correction is effective and specific cited deficiencies remains corrected and/or in compliance with the regulatory requirements is oversight by corporate staff. Corporate oversight will validate the facility's progress, review corrective actions and dates of completion. The Administrator will be responsible for ensuring QAPI committee concerns are addressed through further training or other interventions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB	1028 BLAIR STREET THOMASVILLE, NC 27360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 24	F 867		

nutrition and 1 of 1 sampled resident reviewed for discharge planning.

During the recertification survey on 4/22/21, the facility failed to develop and implement a comprehensive care plan for one of two residents reviewed for care plans.

F690: Based on observations, resident and staff interviews and medical record review, the facility failed to keep a urinary catheter bag from touching the floor to reduce the risk of infection or injury for 1 of 3 residents (Resident #59) reviewed for indwelling urinary catheters.

During the recertification survey on 4/22/21, the facility failed to obtain orders regarding indwelling catheter care in 2 of 3 residents reviewed, orders to change the catheter in 2 of 3 residents reviewed and failed to secure the urinary catheter drainage tubing for 1 of 3 residents reviewed for indwelling urinary catheter.

The Administrator was interviewed on 7/20/23 at 2:40 pm. He stated that the QA members were made up of Administrator, the Director of Nursing, Dietary Manager, Business office manager, Maintenance Director, Social Worker, Activities Director, and Housekeeping Director. The Nurse Supervisor and the Medical Director were always invited to attend. He also stated that the QA committee usually meets quarterly but they have met monthly this year due to new staff. He also added that the facility has to utilized a lot agency staff since Covid began and he was happy to say that they have recently been able to eliminate all agency staff. He stated the facility has a whole will meet to discuss these issues and investigate new ways to achieve compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB	**1028 BLAIR STREET THOMASVILLE, NC 27360**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE