STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	09/11/2015

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0224 **Level of harm -** Actual harm **Residents Affected -** Few	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and staff interviews the facility neglected to provide treatments as ordered by a wound care physician for reoccurrence of a stage 4 pressure ulcer that developed in the facility for 1 of 3 residents sampled for pressure ulcers (Resident #53). The findings included: Resident #53 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the most recent annual Minimum Data Set ((MDS) dated [DATE] indicated Resident #53 was moderately impaired in cognition for daily decision making. The MDS indicated Resident #53 required extensive assistance with activities of daily living and was at risk for development of pressure ulcers. A review of a nurse's note dated 08/31/15 at 3:48 PM documented by the treatment nurse indicated a pressure ulcer to coccyx was resolved. A review of a physician's orders [REDACTED]. A review of documents dated 09/02/15 from a wound center titled Discharge Instruction Summary indicated Resident #53 had a stage 4 pressure ulcer on his sacrum with measurements of 8.0 cm length x 4.7 cm width x 2.0 cm depth. A section labeled primary wound dressing indicated [MEDICATION NAME] Alginate on top of wound but not inside, sacral border dressing, skin prep on intact skin around wound bed and change daily and as needed for soiling and barrier cream to anal and perineal area to reduce excoriation of skin. A review of a treatment record dated 09/02/15 through 09/08/15 revealed there were no treatments documented for a pressure ulcer. During an interview on 09/09/15 at 9:37 AM with Nurse Aide (NA) #10 she stated there was redness on Resident #53's buttocks but he went to the wound clinic and all they had to do was to keep him clean and dry. She stated she was not aware of any barrier cream for Resident #53's skin on his buttocks. During an observation and interviews on 09/09/15 at 10:12 AM the Director of Nursing (DON) and treatment nurse entered Resident #53's room and the treatment nurse stated she had received a skin referral to evaluate Resident #53 ' s sacrum. Resident #53 was turned to his left side and the treatment nurse removed an adhesive dressing from Resident #53's sacrum and there was a large open area that was dark in the center of the wound with raw skin around the edges with skin peeled back and an open hole at bottom of wound. The treatment nurse measured the wound and stated the wound was 10 cm length x 8.5 cm width x 1.2 cm depth and was unstageable because she could not see the wound bed. The DON stated staff were supposed to check Resident #53's skin on his shower days and if they saw skin problems they were supposed to report it to the nurse. She further stated Resident #53 did not like to turn off his back and frequently he slid down in bed with his bottom in a depression that was caused by a fold in the air mattress when the head of the bed was raised. The treatment nurse explained Resident #53 looked like he was sitting in a ditch when he slid down into the crease of the mattress and he would not reposition himself. She stated she was very surprised to see the pressure ulcer on Resident #53's sacrum and thought when staff had pulled him up in bed they had sheared the skin off his bottom and now the skin had dried out and had eschar (dead tissue). She further stated Resident #53 had previously had a stage 4 pressure ulcer on the right side of his sacrum that had a small hole with exposed bone but it was not in the same location as the current pressure ulcer. During an interview on 09/10/15 at 10:38 AM Nurse #1 explained she was assigned to care for Resident #53 last week and she stated she remembered his bottom was red but did not remember anything else about his skin. She stated she might have put a dressing on his bottom since it was red but could not remember exactly what she did. She further stated she was not aware of treatment orders from the wound clinic on 09/02/15 and had not received reports from other nurses that Resident #53 had a new pressure ulcer or had new treatment orders from the wound clinic on 09/02/15. During an observation on 09/10/15 at 12:15 PM Resident #53 was in bed with the head of the bed raised and was flat on his back with his bottom down in the depression in the fold of an air mattress which was set on a low pressure setting at a control unit located on the footboard of the bed. During an interview on 09/10/15 at 12:25 PM with the Physician's Assistant she stated it was her expectation for nursing staff to assess resident's skin and let her or the physician know if there were problems or issues. She explained nursing staff could call anytime 24 hours a day or they could leave a note in the physician's communication book and they would see residents when they made rounds. She further stated if a wound was worse or looked infected they should let her or the physician know about it. She explained she felt wound treatments were not always provided consistently and she was not always informed about wounds that needed treatment. She stated staff in the facility were their eyes and ears and staff had to tell her or the physician when something needed to be addressed. She explained she had made rounds in the facility on 09/07/15 but she did not see Resident #53 because she was not aware he had a wound on his sacrum. She further stated she expected staff to turn and reposition Resident #53 even if he did not want to turn to keep him off his bottom to prevent skin breakdown. During an observation on 09/10/15 at 3:04 PM Resident #53 was lying flat on his back with the head of the bed up with his bottom down in the depression in the fold of the air mattress. During an observation on 09/10/15 at 5:39 PM Resident #53 was lying flat on his back in bed with the head of the bed up with his bottom down in the depression in the fold of the air mattress. During a telephone interview on 09/11/15 at 9:11 AM with the wound care physician he confirmed he had seen Resident #53 earlier that morning and he had a big wound on his sacrum that had to debrided (surgical removal) of necrotic (dead) tissue. He stated he was very surprised to see the condition of the wound since Resident #53 had a healing wound when he was seen in the wound clinic in August. He further stated he could not remember specifics about the wound because he did not have the resident's chart in front of him but the nurse would provide the information. He explained he had ordered wet to dry dressings on Resident #53's wound since he had removed dead tissue from it that morning and it was his expectation for dressings to be changed as ordered, turn and reposition Resident #53 and provide an air mattress to relieve pressure. He further stated pressure should be avoided to promote wound healing. During an interview on 09/11/15 at 9:58 AM with a facility transporter who also was a Nurse Aide (NA) she verified she had transported Resident #53 to the wound clinic earlier that morning and she stayed with the resident in the treatment room when he saw the wound physician. She stated Resident #53 had a large wound on his bottom that did not smell good and it looked worse than the previous time she had transported him to the wound clinic on 09/02/15. She stated prior to that on 08/30/15 the wound on his bottom was looking really good. She further explained the wound clinic usually sent paperwork

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

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F 0224 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) back with the resident to the facility and she gave the paperwork to the nurse. During a follow up interview on 09/11/15 at 10:32 AM with the treatment nurse she explained she saw Resident #53's skin on 08/31/15 and the pressure ulcer she had been treating on his coccyx had healed and was pink with scar tissue. She stated she called the nurse practitioner who discontinued the treatment orders and she called the wound clinic to tell them the pressure ulcer had healed. She explained she did not realize Resident #53 went to his scheduled appointment at the wound clinic on 09/02/15 because no one had told her he had gone or that he had a new pressure ulcer until she got a skin referral on 09/09/15 and saw Resident #53 on 09/10/15. She confirmed the dressing she removed on 09/10/15 was a [MEDICATION NAME] sacrum border dressing but she did not know how long the dressing had been on the resident or who had put the dressing on because staff did not initial dressings with a date when a dressing was applied. She stated the facility had used staff from other facilities to fill in vacant positions and it was possible staff had not done treatments since they were not always familiar with residents or routines. She explained staff should turn and reposition Resident #53 to alleviate the pressure but it was a challenge because he preferred to lay on his back and did not like to turn or get out of bed. She further explained the new pressure ulcer on his sacrum looked like his skin had been sheared off when he had been pulled up in bed. She confirmed she was the wound treatment nurse in the facility but had also been assigned to work as a nurse on the halls to fill in for vacancies so she had to rely on nurses to let her know if resident's had red or broken areas of skin. She explained it was her expectation for staff to put a skin referral in the computer if a resident had skin breakdown so that she could assess them. She stated nurses had access to dressings and wound supplies and when she was not on duty they should have done treatments and should have told her about Resident #53's new pressure ulcer. She explained, after review of Resident #53's treatment records, there were no treatments documented for Resident #53's pressure ulcer from 09/02/15 through 09/08/15 because there was no documentation of Resident #53's clinic visit notes or orders in his medical record She explained usually the transporter brought back paperwork from the wound clinic and gave it to a nurse but she did not know if it was lost or what had happened. She verified nurses were supposed to write their initials on the treatment record when they provided treatments but since there were no initials the treatments were probably not done. She explained since she had not seen the wound clinic notes dated 09/02/15 other nurses were probably not aware of the treatment orders either and that could explain why treatments weren't done. During a telephone call on 09/11/15 at 11:00 AM from a nurse at the wound center she reported the following clinic visits for Resident #53: 09/02/15 wound measurements 8.0 cm length x 4.7 cm width x 2.0 cm depth with treatment of [REDACTED]. 09/11/15 wound measurements 11.7 cm length x 9.0 cm width x 2.3 cm depth with treatment of [REDACTED]. During an interview on 09/11/15 at 5:40 PM the DON stated it was her expectation for the transporter to bring orders from the wound clinic to the nurse when a resident returned to the facility. She further stated the nurse assigned to the resident needed to review the orders and the treatment nurse needed to review the orders and follow through with the treatment orders. She stated they needed to improve the communication system and if the nurse was not available when the transporter brought the resident back to the facility or the treatment nurse was not available the documents should be given to the DON. She confirmed there was no system for weekly skin checks but they needed a better system for skin assessments and skin referrals. She stated it was her expectation for treatments to be done daily or as ordered by the physician and if there was no treatment nurse on duty the nurse assigned to the resident should do the treatments. She further stated if there were no staff initials on the treatment records she interpreted it as the treatment was not provided.
F 0241 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide care for residents in a way that keeps or builds each resident's dignity and respect of individuality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff and resident interviews, the facility failed to provide a bed pan upon request and failed to help obtain matching shoes after staff were informed of lost shoes for 2 of 4 residents (Residents # 26 and #56). The findings included: 1) Resident #56 was admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. The most recent Urinary Incontinence Care Area assessment dated [DATE] stated Resident #56 was usually continent of urine and used the bedpan, telling staff when she needed to use the restroom. She required assistance placing her on the bedpan and cleansing her. Her most recent Minimum Data Set ((MDS) dated [DATE] coded her with intact cognition (scoring a 13 out of 15 on the Brief Interview for Mental Status), requiring extensive assistance with most activities of daily living skills including toileting, and being always incontinent of bladder. The current Care Plan addressing occasional urinary incontinent related to physical immobility which was last reviewed on 07/20/15, included the intervention to encourage the resident to call for assist if needed for toileting. On 09/11/15 at 7:44 AM, Resident #56 was observed in bed with her uncovered tray in front of her. She stated she needed to urinate and had requested a bed pan but was told by the nurse aide that she had to pass the trays on the hall first. Resident #56 stated she did not think she could wait that long to use the bed pan as she really had to use the bedpan. After activating the call light again, NA #1 came into the room and confirmed Resident #56 had asked for a bed pan and NA #1 did tell her she could not place her on the bedpan until the trays were passed. At this time NA #2 entered the room to assist with repositioning. NA #2 and NA #1 stated they were trained in school that they could not assist a resident with toileting or placing them on a bed pan while the trays were being passed because it was a breach of infection control. At this time, NAs #1 and #2 placed Resident #56 on the bed pan. At 7:54 AM, NA #2 stated Resident #56 was continent when placed on the bedpan. Interview with the Director of Nursing on 09/11/15 at 6:25 PM revealed she expected staff to assist Resident #56 or any resident with toileting upon request even during tray pass. On 09/11/15 at 6:50 PM, Resident #56 stated it made her mad to be told staff could not assist her to the bedpan this morning. 2) Resident #26 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #26 required limited assistance with dressing, hygiene and bathing with 1 person physical assist. Resident #26 is alert and oriented to person, place, time and current events. During an interview on 09/10/15 at 5:20PM, Resident #26 stated concerns about wearing 2 different shoes that have been worn daily since the mates to the shoes have been missing. This occurred in July 2015 when Resident #26 moved from the lower floor in the facility to the upper floor. Resident #26 stated that he told staff several times that the mates to the shoes were missing and 2 staff members were aware and joked about it. Resident #26 had received physical and occupational therapy since July 2015. Resident #26 acknowledged a difference in each shoe when attempting to transfer, stand and walk. When asked about wearing two different shoes, Resident #26 stated, I don't like it, but I have to wear something. The only other pair of shoes I have is dress shoes. Resident #26 was observed using his upper and lower extremities to propel himself in his room and the hallway by wheelchair. Resident #26 was observed to be wearing 2 different shoes. On 09/11/15 9:06 AM the Physical Therapy Assistant (PTA) stated that Resident #26 told him someone had lost his shoes and now he was stuck wearing 2 different shoes. PTA stated that he did not report this to anyone because he assumed they already knew about the missing mate to each pair of shoes. On 09/11/15 at 9:08 AM the Occupational Therapist (OT) stated she remembers Resident #26 saying that the mate to each pair of shoes was missing. OT stated this was about 6 weeks ago and remembers Resident #26 mentioning this more than once. OT stated she did not report this to anyone because she thought they already knew about the missing mate to each pair of shoes. On 09/11/15 at 9:16 AM the Certified Nursing Assistant #2 (CNA #2) stated that if a resident told him about a missing item, he would search the resident's room and notify laundry if the item wasn't found. CNA #2 stated he would correct the inventory sheet if the item wasn't found and would not need to notify anyone else. On 09/11/15 at 9:55 AM the Rehab Director (RD) stated if a resident did not have matching shoes it may affect his or her

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F 0241 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) ability to perform therapy appropriately and this was a cause for concern. RD stated she would follow up with this by talking with the Social Services Director (SSD) directly or completing a patient concern form about this and would expect her employees to do the same. On 09/11/15 at 5:11 PM the SSD stated that she had not been made aware of the missing mate to each pair of shoes for Resident #26 until today.
F 0242 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure each resident has the right to have a choice over activities, their schedules and health care according to his or her interests, assessment, and plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident, and staff interviews, the facility failed to assist a resident with showers for 1 of 3 residents who were reviewed for choices (Resident #46). The findings included: Resident #46 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set ((MDS) dated [DATE] indicated Resident #46 was cognitively intact and was able to understand and make self-understood. Resident #46 required extensive assistance with bathing. Resident #46 was able to participate in the interview related to preferences at which time he stated his preference of a shower was very important to him. Review of a care plan, which indicated last completed, was dated 06/16/15 revealed Resident #46 required assistance for bathing due to impaired mobility with interventions for 2 persons to provide physical assist with bathing and resident prefers showers. On 09/08/15 at 2:52 PM, an interview was conducted with Resident #46. The resident stated he was not provided assistance with showering 2 times per week. He indicated he was supposed to have a shower on Monday and Thursday of every week and he was only getting his showers once a week and sometimes not at all. Resident #46 further indicated his last shower was on Monday, 08/24/15. Review of the bathing records dated 08/06/15 through 09/09/15 revealed Resident #46 had received a shower on 08/13/15, 08/17/15, 08/24/15, 08/29/15, 09/03/15, and 09/07/15. A full bed bath was indicated on 08/08/15, 08/21/15, 08/27/15, and 09/06/15. The bathing records were obtained with no one identified as to who had put the information into the computer system. On 09/11/15 at 9:45 AM, an interview was conducted with Resident #46. The resident stated he was capable of shaving himself with his electric razor and completing most of his personal hygiene needs except for his showers. He indicated he needed assistance with showering and that he had not had a shower since 08/24/15 due to the facility being short staffed. Resident #46 also indicated the NAs had assisted him with a bed bath and he had asked for a shower and the staff had told him they would give him a shower as soon as they had time. Resident #46 stated he thought staff was just too busy to worry about assisting him with his showers. An interview was conducted on 09/11/15 at 10:15 AM with Nurse #1. She stated she had been assigned to assist on the halls in the capacity of a Nurse Aide due to the halls being short staffed. She further stated the NAs could not keep the residents clean, dry, complete showers, and the ADLs were not getting done due to lack of staffing. Nurse #1 reported she was unable to recall the last time Resident #46 had a shower. She indicated when showers were given the NAs would write it down in the shower book. Nurse #1 confirmed Resident #46 had a shower on 08/24/15 and no other showers had been reported in the shower book. A review of the shower book dated 08/17/15 through 09/10/15 revealed Resident #46 had a shower on 08/17/15 and on 08/24/15. There was no documentation in the shower book that indicated Resident #46 had a shower after 08/24/15. The shower book was maintained at the nurses' station and the information was manually documented by the NAs in regards to showers, nail care, or shaving of a resident. An interview was conducted on 09/11/15 at 10:30 AM with Nurse #2. She stated there had been times when residents would not get their showers on their scheduled days due to the facility being short staffed. Nurse #2 stated she was unaware Resident #46 had not had a shower since 08/24/15. An interview was conducted on 09/11/15 at 1:30 PM with NA #1. She stated the NAs worked short staffed most days and they no longer had a shower team. She further stated it was almost impossible to complete all care sure as showers, nail care, shaving, oral care, and making and changing of bed linens. She indicated as short staffed as they were they focused on toileting, changing, and feeding of the residents and the other care needs were completed on a day when extra staff was working. NA #1 reviewed the shower book and verified Resident #46 had a shower on 08/24/15 and no other shower was indicated since that day. An interview was conducted on 09/11/15 at 1:45 PM with NA #4. She stated she worked as a nurse aide on which ever hall was short staffed for that day. She further stated the 2 halls worked short staffed most days and that resident care needs such as showers, nail care, oral care and shaving were not provided on a scheduled weekly basis. She indicated when she worked as a float NA she would be assigned to give resident showers but for the last 2 to 3 months she had worked as a regular staffed NA. NA #4 verified she had assisted Resident #46 with a shower on 08/24/15 and had not assisted the resident with a shower since that day. An interview was conducted with the Director of Nursing (DON) on 09/11/15 at 8:00 PM. She stated it was her expectation that all care should be provided to the resident and if certain care areas were missed they should be reported for the next shift to do. The DON further stated she did not know what needs were not being met for the residents due to staffing. She indicated that showers should be given at least twice per week and as the resident preferred.
F 0246 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, medical record reviews, resident, family, and staff interviews the facility failed to place call bells within reach for 2 of 3 sampled residents (Residents #11 and #59). The findings included: 1) Resident #11 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set ((MDS) dated [DATE] indicated Resident #11 had short and long term memory impairment and severely impaired cognitive skills for daily decision making. Resident #11 was characterized as usually making self-understood and responded adequately to simple direct communication. Resident #11 required extensive assistance with activities of daily living (ADLs) including bed mobility, transfers, eating, personal hygiene, and dressing and was totally dependent on staff for bathing. Resident #11's care plan dated 07/20/15 was reviewed for falls. The care plan specified the resident was at risk for falls characterized by multiple risk factors related to a history of falls, impaired balance, impaired mobility, and impaired cognition. Current approaches included: · Encourage resident to obtain assistance for transfers and mobility · Bed in low position · Place call light in reach · Encourage resident to call for assistance On 09/10/15 at 3:20 PM, Resident #11 was observed setting in her bed, arthritic hands, and minimal movement of her arms, alert and oriented, and her call bell was observed to be down between the right side of the bed and the side rail touching the floor. Resident #11 was observed unable to find and/or reach her call bell. On 09/10/15 at 3:30 PM, an interview was conducted with Resident #11, when asked how she would call for help the resident responded, I don't know. When the resident was asked if she would use her call bell, the resident replied, I can't find it. When the resident was asked if she would be able to use the call bell if she had it in reach, the resident responded, yes that is how I get them to help me. On 09/10/15 @ 3:57 PM, observed Nurse #2 go into Resident #11's room to administer medication and the nurse did not provide the resident with her call bell and the call bell remained down between the right side of the bed and the side rail touching the floor. On 09/10/15 at 4:00 PM, an interview was conducted with Nurse #2. She stated she was expected to ensure the call bell was

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Nurse #2 was observed to not unwrap the call bell from around the side rail and ensure the call bell was within the resident's reach. The following observations were made of the call bell to be wrapped around the right side rail of the bed and out of the resident's reach on 09/11/15 at 8:20 AM, on 09/11/15 at 9:15 AM, on 09/11/15 at 11:30 AM, on 09/11/15 at 12:45 PM, on 09/11/15 at 1:10 PM, and on 09/11/15 at 2:00 PM. On 09/11/15 at 8:00 PM, the Director of Nursing (DON) was interviewed. She confirmed the staff were trained and expected to keep residents' call bells in reach. The DON stated staff members make daily rounds and it was everyone's responsibility to ensure call bells were within reach. No explanation was offered why the resident was observed during the survey to not have her call bell in reach. 2) Resident #59 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set ((MDS) dated [DATE] indicated Resident #59 was characterized as making self-understood and responded adequately to direct communication. Resident #59 was independent with bed mobility, transfers, ambulation, and eating, and required extensive assistance with dressing, toileting, and personal hygiene. Resident #59's care plan dated 07/20/15 was reviewed for falls. The care plan specified the resident was at risk for falls characterized by history of falls/actual falls, injury, multiple risk factors related to impaired balance and impaired cognition. Current approaches included: · Encourage resident to obtain assistance for transfers and mobility · Fall mat in floor when in bed · Place call light in reach · Encourage resident to call for assistance · Ensure alarms are functional Observations made of Resident #59 on 09/10/15 at 12:15 PM revealed the resident seated in a recliner placed approximately 2 feet away from the left side of the resident's bed. The resident's call bell was observed to be clipped to the resident's pillow located at the head of the bed behind the resident's recliner and out of reach of the resident. On 09/10/15 at 12:30 PM, an interview was conducted with Resident #59's family member. She stated the resident was unable to push down the foot rest of the recliner as to allow him to get up independently. She further stated Resident #59 was capable of using the call bell but not unless it was within his reach. On 09/10/1 at 12:35 PM, an interview was conducted with Resident #59, when asked how he would call for help the resident responded, I don't know. When the resident was asked if he would use the call bell, the resident replied, I don't know where it is because I can't find it. When the resident was asked if he would be able to use the call bell if he had it in reach, the resident responded, yes I use it to get help when I can find it. Observations made of Resident #59 on 09/11/15 at 7:35 AM revealed the resident was sitting in the recliner, the foot rest up, soiled, and the call bell was lying behind the resident's recliner in the floor and not within reach. The resident stated, I am so wet can you please help me when asked where his call bell was the resident stated I don't know, I can't ever find it and they will not help me. On 09/11/15 at 8:00 AM, Nurse #3 was observed to go into Resident #59's room with his breakfast tray. Nurse #3 called out for Nurse Aide (NA) #2 to assist the resident. NA #2 was observed to complete incontinent care for the resident, transfer him to the wheelchair, and setup his breakfast meal on the over-bed table. NA #2 was observed to not pick up and/or placed the call bell within the resident's reach before he exited the room. On 09/11/15 at 8:30 AM, an interview was conducted with NA #2. He stated he was busy and had forgotten to place the call bell in reach of the resident. On 09/11/15 at 8:00 PM, the Director of Nursing (DON) was interviewed. She confirmed the staff were trained and expected to keep residents' call bells in reach. The DON stated staff members make daily rounds and it was everyone's responsibility to ensure call bells were within reach. No explanation was offered why the resident was observed during the survey to not have her call bell in reach.
F 0253 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide housekeeping and maintenance services.** Based on observations and staff interviews the facility failed to label bedpans and bath basins with resident names (resident room #86, #87, #105 and #106), failed to clean a privacy curtain in a resident's room (room #99), failed to store lift slings and straps off the floor (receptionist area), failed to repair damaged handrails (main hall), failed to repair base molding (between resident rooms #100 and #101, receptionist area and across from nurses station on the main hall), failed to repair broken laminate on a cabinet (room #100) and failed to repair broken areas of wood and laminate on smoke prevention doors (100 hall). The findings included: 1. a. Observations on 09/08/15 at 11:31 AM in the bathroom of room #86 revealed there was a bed pan in a plastic bag lying on the floor and there was no name visible on the bedpan. Observations on 09/09/15 at 11:30 AM in the bathroom of room #86 revealed there was a bed pan in a plastic bag lying on the floor and there was no name visible on the bedpan. Observations on 09/10/15 at 3:09 PM in the bathroom of room #86 revealed there was a bed pan in a plastic bag lying on the floor and there was no name visible on the bedpan. b. Observations on 09/08/15 at 11:34 AM revealed in the bathroom of room #87 there was a bed pan lying on top of a bucket of a bedside commode with another bedpan in a plastic bag on top of it and there were no names visible on the bedpans. Observations on 09/09/15 at 8:52 AM revealed in the bathroom of room #87 there was a bed pan lying on top of a bucket of a bedside commode with another bedpan in a plastic bag on top of it and there were no names visible on the bedpans. Observations on 09/10/15 at 3:09 PM revealed in the bathroom of room #87 there was a bed pan lying on top of a bucket of a bedside commode with another bedpan in a plastic bag on top of it and there were no names visible on the bedpans. c. Observations on 09/09/15 at 08:40 AM revealed in the bathroom of room #105 there were 2 bath basins stacked inside each other and no resident name was visible on the bath basins. Observations on 09/10/15 at 9:31 AM revealed in the bathroom of room #105 there were 2 bath basins stacked inside each other and no resident name was visible on the bath basins. Observations on 09/10/15 at 3:09 PM revealed in the bathroom of room #105 there were 2 bath basins stacked inside each other

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	345219	A. BUILDING _____ B. WING _____	09/11/2015

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0253 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) and no resident name was visible on the bath basins. d. Observations on 09/08/15 at 3:17 PM revealed in the bathroom of room #106 there was a bedpan propped on its side on top of a handicapped rail next to the commode. There was no name visible on the bedpan. Observations 09/09/15 at 9:19 AM revealed in the bathroom of room #106 there was a bedpan propped on its side on top of a handicapped rail next to the commode. There was no name visible on the bedpan. Observations on 09/10/15 at 3:09 PM revealed in the bathroom of room #106 there was a bedpan propped on its side on top of a handicapped rail next to the commode. There was no name visible on the bedpan. On 09/11/15 at 1:01 PM NA #11 stated she worked on all halls in the facility. She stated bedpans and bath basins should be placed in a plastic bag and they were usually hung on the handicapped rails in the bathrooms. She stated bedpans and bath basins were supposed to have the resident's name written with a black marker so the name was visible. During an interview and tour on 09/11/15 at 4:12 PM with the Director of Nursing she stated it was her expectations for bedpans and bath basins to be stored in plastic bags and labeled with the resident's name clearly visible on them. She further stated bed pans and bath basins should be placed in the resident's closet and out of sight until staff needed to use them. She also stated bath basins should not be stacked inside each other but should be individually bagged and labeled with the resident's name and stored out of view. 2. An observation on 09/08/15 at 4:25 PM in resident room #99 revealed a stained privacy curtain that also had a dried substance on the curtain. An observation on 09/10/15 at 9:31 AM in resident room #99 revealed a stained privacy curtain that also had a dried substance on the curtain. An observation on 09/10/15 at 3:09 PM in resident room #99 revealed a stained privacy curtain that also had dried substance on the curtain. During a tour and interview on 09/11/15 at 4:12 PM with the Director of Nursing she stated it was her expectation for housekeeping to clean privacy curtains on a routine basis. She further stated staff should report to housekeeping when they observed soiled privacy curtains so they could be replaced or cleaned. During an interview on 09/11/15 at 4:45 PM with the Housekeeping Supervisor he explained housekeeping staff were supposed to take privacy curtains down once per month for cleaning but sometimes it occurred every other month. He stated if privacy curtains were visibly dirty then housekeeping staff should take them down and clean them. He further stated he relied on nursing staff and housekeeping staff to observe and report concerns and he expected for staff to make sure the curtains were clean. 3. Observations on 09/08/15 at 10:24 AM during a tour of the facility revealed an area labeled receptionist that had a sit to stand mechanical lift and a total body lift parked in the space. A lift sling for the total body lift was lying on the floor between the 2 lifts. Observations on 09/09/15 at 9:07 AM revealed the receptionist area had a sit to stand mechanical lift and total body lift parked in the space. A strap that attached to a lift pad for the sit to stand lift was lying in the floor next to the total body lift. Observation on 09/10/15 at 3:09 PM revealed the receptionist area had a sit to stand mechanical lift and a total lift parked in the space. A strap that attached to a lift pad for the sit to stand lift was lying in floor next to the total body lift. Observation on 09/11/15 at 1:04 PM revealed the receptionist area had a sit to stand mechanical lift and a total lift parked in the space. A strap that attached to a lift pad for the sit to stand lift was lying in floor next to the total body lift. During a tour and interview on 09/11/15 at 4:12 PM with the Director of Nursing she stated slings and straps for lifts were supposed to be stored in the shower room or supply room. She acknowledged the strap that attached to a lift pad was lying in the floor of the room labeled receptionist and stated lift straps and slings should not be left in the floor but should be stored properly to keep them clean. 4. a. Observations on 09/08/15 at 10:09 AM during an initial tour of the facility revealed the handrails on the main hall from the nurse's station to the end of the hall at the dining room on both sides of the hall had areas of chipped wood with rough areas to the touch and rough corners with chipped wood. Observations on 09/09/15 at 9:07 AM revealed the handrails on the main hall from the nurse's station to the end of the hall at the dining room on both sides of the hall had areas of chipped wood with rough areas to the touch and rough corners with chipped wood. Observations on 09/10/15 at 3:09 PM revealed the handrails on the main hall from the nurse's station to the end of the hall at the dining room on both sides of the hall had areas of chipped wood with rough areas to the touch and rough corners with chipped wood. b. Observations on 09/08/15 at 10:09 AM during an initial tour of the facility revealed the base molding at the floor was broken and had peeled away from the wall with pointed edges between resident room #100 and #101. Observations on 09/09/15 at 9:07 AM revealed the base molding at the floor was broken and had peeled away from the wall with pointed edges between resident room #100 and #101. Observations on 09/10/15 at 3:09 PM revealed the base molding at the floor was broken and had peeled away from the wall with pointed edges between resident room #100 and #101. c. Observations on 09/08/15 at 10:09 AM during an initial tour of the facility revealed the base molding at the floor was broken and had peeled away from the wall with pointed edges at the corner of the main and central halls. Observations on 09/09/15 at 9:07 AM revealed the base molding at the floor was broken and had peeled away from the wall with pointed edges at the corner of the main and central halls. Observations on 09/10/15 at 3:09 PM revealed the base molding at the floor was broken and had peeled away from the wall with pointed edges at the corner of the main and central halls d. Observations on 09/08/15 at 10:09 AM during an initial tour of the facility revealed the base molding at the floor was broken and had peeled away from the wall with pointed edges on the main hall across from the nurse's station. Observations on 09/09/15 at 9:07 AM revealed the base molding at the floor was broken and had peeled away from the wall with pointed edges on the main hall across from the nurse's station. Observations on 09/10/15 at 3:09 PM revealed the base molding at the floor was broken and had peeled away from the wall with pointed edges on the main hall across from the nurse's station. e. Observations on 09/08/15 at 10:09 AM during an initial tour of the facility revealed large areas of laminate was broken with rough edges on a cabinet in resident room #100. Observations on 09/09/15 at 9:07 AM revealed large areas of laminate was broken with rough edges on a cabinet in resident room #100. Observations on 09/10/15 at 3:09 PM revealed large areas of laminate was broken with rough edges on a cabinet in resident room #100. f. Observations on 09/08/15 at 10:09 AM during an initial tour of the facility revealed broken areas of wood and laminate on the edges of the bottom half of the smoke prevention doors on the main hall. Observations on 09/09/15 at 9:07 AM revealed broken areas of wood and laminate on the edges of the bottom half of the smoke prevention doors on the main hall. Observations on 09/10/15 at 3:09 PM revealed broken areas of wood and laminate on the edges of the bottom half of the smoke prevention doors on the main hall. During an environmental tour and interviews on 09/11/15 at 4:25 PM with the Maintenance Director and the Administrator the Maintenance Director stated he was the only maintenance staff at the facility. He explained he did not have a preventive maintenance plan to repair handrails on base molding in hallways. He stated he made rounds in the facility periodically and when he saw things that were broken he fixed them. He further stated he had fixed loose handrails in the hallways but he had not done any patching of the broken wood or rough edges. He explained he had work orders for staff to fill out that were in a box mounted on the wall next to his office door and he checked the box daily to see what staff had reported that needed repair. He verified he had received no work orders for handrails or damaged base molding or damaged cabinets or damaged wood at the edges of the smoke prevention doors. The Administrator stated it was her expectation for environmental issues to be identified and repaired as soon as possible. She further stated it was everyone's responsibility to report concerns when they saw them so they could be fixed and the maintenance director could prioritize the order of the repairs.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0253 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5)
F 0254 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide clean bed and bath linens that are in good condition.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident, and staff interviews the facility failed to provide bed linens in clean condition for 1 of 1 resident reviewed for cleanliness of bed linens (Resident #46). The findings included: Resident #46 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set ((MDS) dated [DATE] indicated Resident #46 was cognitively intact and was able to understand and make self-understood. Resident #46 required extensive assistance with bathing. Review of the facility record shower list revealed Resident #46 was scheduled to receive showers on Monday and Thursday. On 09/08/15 at 3:20 PM, Resident #46 was interviewed. The resident stated the bed linens were not changed on shower days all the time. Resident #46 indicated his last shower was on 08/24/15 and that his bed linens had not been changed since his last shower day. On 09/09/15 at 9:23 AM, Resident #46's bed was observed to be unmade, wrinkled sheets, an oily looking stain on the pillowcase where the resident's head would have laid, the fitted bed sheet was observed to have a tan colored stain halfway down on the right side, and a tan colored stain in the top middle portion of the fitted sheet as to where the buttocks would have been. On 09/10/15 at 11:40 AM, Resident #46's bed was observed to be unmade, an oily looking stain on the pillowcase and the bed linens was observed to have a tan colored stain half way down on the right side of the fitted sheet and a tan colored stain in the top middle portion of the fitted sheet as to where the buttocks would have been. On 09/11/15 at 9:30 AM, an observation was made of Resident #46 setting in his room in his wheelchair. The bed linens was observed to be wrinkled with an oily looking stain on the pillowcase. Further observation of the fitted bed sheet was a tan colored stain half way down on the right side and a tan colored stain in the top middle portion of the fitted sheet as to where the buttocks would have been. On 09/11/15 at 9:45 AM, an interview was conducted with Resident #46. The resident stated the bed linens were supposed to be changed on shower days and that his bed linens were soiled and had not been changed since his last shower on 08/24/15. Resident #46 stated he thought staff was just too busy to worry about changing bed linens or assisting with showers. An interview was conducted on 09/11/15 at 10:30 AM with Nurse #2. She stated she expected the bed linens to be changed on the resident's shower days or more often if needed. Nurse #2 confirmed the tan colored stains on Resident #46's bed linens and stated she would have the linens changed immediately. An interview was conducted on 09/11/15 at 1:30 PM with NA #1. She stated the NAs were expected to change the bed linens on the residents shower days. NA #1 further stated it was almost impossible to complete all care sure as showers and making and changing of bed linens. She indicated as short staffed as they were they focused on toileting, changing, and feeding of the residents and the other care needs were completed on a day when extra staff was working. NA #1 stated she was unaware of the stains on Resident #46's bed linens and was unable to recall the last time she had assisted the resident with a shower or had changed the bed linens. An interview was conducted on 09/11/15 at 1:45 PM with NA #4. She stated she was expected to change the bed linens on the residents scheduled shower days. NA #4 stated the 2 halls worked short staffed most days and that resident care needs such as showers and changing of the bed linens was not provided on a scheduled weekly basis. NA #4 verified she had assisted Resident #46 with a shower on 08/24/15 and had changed his bed linens at that time. An interview was conducted with the Director of Nursing (DON) on 09/11/15 at 8:00 PM. She stated it was her expectation that all care should be provided to the resident and if certain care areas were missed they should be reported for the next shift to do. The DON further stated she did not know what needs were not being met for the residents.

F 0272 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Conduct initial and periodic assessments of each resident's functional capacity.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to complete Care Area Assessments that addressed the underlying causes, contributing factors and risk factors for triggered areas for 3 of 17 (Residents #25, #53, and #56) sampled residents. The findings included: 1. Resident #53 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. His annual Minimum (MDS) data set [DATE] coded him with moderate cognitive impairment, requiring extensive assistance with most activities of daily living skills (ADLs) including bed mobility, transfers and toileting and having no pressure ulcers. The Care Area Assessments (CAA) dated 08/04/15 did not include an analysis including the description of the problem, causes and contributing factors and risk factors for cognition, activities of daily living skills (ADLs), urinary incontinence and pressure ulcers as follows: *Cognition CAA stated he had long term memory impairment noted for the year and month. His short term memory was fairly good related to recall of items in 5 minutes. The CAA failed to state how his cognition affected his day to day activity level or care. *ADL CAA stated he required staff assistance for ADLs, being unable to stand on his own and needing staff assistance for bed mobility. There was no other information related to any strengths he had or analysis of the information to determine if he could improve. *Incontinence CAA stated he was incontinent needed staff assistance with activities of daily living skills. The CAA failed to identify a previous [MEDICATION NAME] which resulted in a unhealed fistula which leaked urine. Nor did the CAA address how the incontinence affected his day to day life. *Pressure ulcer CAA noted he was at risk for pressure ulcers as he stayed in bed all the time and needed staff assistance with bed mobility and perineal care. The CAA failed to identify previous pressure ulcers located on his coccyx. Interview with the MDS Nurse on 09/11/15 at 1:52 PM revealed that she completed the CAAs for Resident #53 which were signed by the Director of Nursing. She stated that since Resident #53 was such a long term resident, she didn't think to put in details of the resident's past history or individual preferences and behaviors like she would if the resident was a new admit to the facility. 2. Resident #56 was admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. The annual Minimum Data Set ((MDS) dated [DATE] coded Resident #56 with intact cognition, requiring extensive assistance for most activities of daily living skills (ADLs), having range of motion limitation on one side of her upper extremities, occasionally incontinent of bladder, and receiving physical and occupational therapies. The Care Area Assessments (CAA) dated 04/20/15 did not include an analysis including the description of the problem, causes and contributing factors and risk factors for activities of daily living skills (ADLs) or urinary incontinence as follows: *ADLs CAA stated the resident required extensive assistance from staff to complete ADLs other than eating. The CAA identified the resident's history of a [MEDICAL CONDITION] and splint being worn, however, there was no indication as to her strengths, the fact she was receiving skilled therapies or expected progress. *Incontinence CAA stated she was a long term care resident who was usually continent, used the bedpan, and called for assistance. She was identified as having had a stroke but there was no analysis of the reason she had some incontinence and whether she could improve. Interview with the MDS Nurse on 09/11/15 at 1:52 PM revealed that she completed the CAAs for Resident #56 which were signed by the previous Director of Nursing. She stated that since Resident #56 was such a long term resident, she didn't think to put in details of the resident's individual preferences and behaviors like she would if the resident was a new admit to the facility. 3. Resident #25 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The admission Minimum (MDS) data set [DATE] coded him with intact cognitive skills, having no moods, or behaviors, requiring extensive assist with activities of daily living skills (ADLs), being nonambulatory, and being continent with the use of an indwelling urinary catheter. The Care Area assessment dated [DATE] did not include an analysis including the description of the problem, causes and contributing factors and risk factors for ADLs or urinary incontinence as follows:

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F 0272 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) * ADLs CAA stated Resident #25 was admitted from the hospice house and required extensive assistance from staff for completing ADL's. Weakness was noted and he had multiple [DIAGNOSES REDACTED]. *Urinary incontinence CAA stated he was admitted from hospice house and when there was no reason found for the use of the indwelling urinary catheter, it was removed. He required extensive assistance from staff for repositioning, turning and to give perineal care. It was noted he was unable to get tot he toilet without assistance from staff due weakness noted per therapy notes. There was analysis as to his potential for improvement. Interview with the MDS nurse on 09/11/15 at 5:58 PM revealed she completed this CAA and the previous Director of Nursing signed off on it. She stated that she failed to describe a complete picture of the resident in the ADL or incontinence CAA. She further stated the family decided to try therapy and when she asked him about his ability to use the bathroom, he told the nurse he used his incontinent brief and rang his bell.
F 0280 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Allow the resident the right to participate in the planning or revision of the resident's care plan.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews, the facility failed to revise a care plan for a resident with contractures for 1 of 3 residents reviewed for care plans (Resident #56). The findings included: Resident #56 was admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. A Rehab Communications to Nursing form indicated that restorative services was to begin 02/09/15 for passive range of motion to all joints of the left upper extremities of the shoulder, elbow wrist and hand and use a palm guard in the left hand as often as possible for contracture management. A care plan was initiated on 03/11/15 for range of motion as the resident was at risk for developing further contractures. Interventions included to wear a palm guard to the left hand for 2 - 3 hours a day or as tolerated after hygiene to the palm 4 - 6 days per week. Resident #56 began occupational therapy (OT) on 03/12/15 due to a contracture of the left elbow resulting in episodes of skin breakdown. The resident was noted to require skilled therapy and splint treatment to improve elbow contracture and decrease further risk of contracture. A static progressive splint was to be initiated by therapy to the left elbow. The annual Minimum Data Set ((MDS) dated [DATE] coded Resident #56 with intact cognition (scoring a 13 out of 15 on the Brief Interview for Mental Status), requiring extensive assistance for most activities of daily living skills (ADLs), having range of motion limitation on one side of her upper extremities, and receiving skilled OT. Review of the OT discharge summary revealed the goal for the resident to demonstrate passive range of motion of the left upper extremity extension from 140 to 65 degrees without complaints of pain was met on 05/05/15. OT's discharge summary dated 05/11/15 stated nursing staff (2 names) and restorative care staff (1 name) were trained in range of motion to the left upper extremity and the application of the palm guard and the static progressive splint to the left elbow. The discharge plan and instructions stated nursing and restorative care staff were to perform daily left upper extremity passive range of motion and splint application. The quarterly MDS dated [DATE] coded Resident #56 with intact cognition (scoring a 13 out of 15 on the Brief Interview for Mental Status), requiring extensive assistance for most activities of daily living skills (ADLs), having range of motion limitation on one side of her upper extremities, and receiving no skilled therapy or any restorative nursing program including splinting. The current care plan which addressed Resident #56 being at risk for the development of further contractures was last reviewed on 07/20/15. The interventions included the resident was to wear a palm guard to the left hand 2 - 3 hours per day or as she tolerated after hygiene to palm had occurred 4 to 6 days a week. There was nothing related to a static progressive elbow splint or passive range of motion. Resident #56 was observed with her left hand fisted and left elbow joint tucked in close to her upper arm, with no palm guard or splints in place. Two palm guards, a finger separator and an elbow splint were observed on the adjoining bed/table in her room on 09/08/15 at 11:16 PM and on 09/10/15 at 8:16 AM, at 9:29 AM, at 10:51 AM, and at 11:39 AM. On 09/10/15 at 11:39 AM, the responsible party was visiting and stated she was unsure if the splints were still being applied as she had not seen them on Resident #56 in a while. Resident #56 stated at this time the staff stopped applying the splints a while ago, admitting they hurt her. The splint and palm guard remained off when Resident #56 was observed on 09/10/15 at 2:51 PM. At this time, Nurse Aide (NA) #3 stated he was not sure about splint application and thought that restorative may do something. He further stated he normally worked nights and provided nothing related to splints or range of motion. Interview with the Restorative nurse on 09/10/15 at 2:54 PM revealed Resident #56 was supposed to have a palm guard in place 2 to 3 hours per day as tolerated. She stated she received referrals from therapy. On 09/11/15 at 9:14 AM, the OT stated Resident #56 was to wear an elbow splint and palm guard. She further stated there were two palm guards, one hard and one soft. She stated that depending on the resident's hand tightness, staff could choose between the hard or soft palm guards. The palm guard was to be used 6 days per week. OT was unaware of any refusals by the resident or problems with the palm guard or elbow splint. Therapy staff provided the handwritten referral named Rehab Communication to Nursing that indicated restorative was to start 05/11/15. This form indicated passive range of motion was to be provided to the left should, elbow, wrist and fingers and a left elbow splint was to be applied 4 hours or over night six times per week. This referral was signed by OT and NA #1. Interview on 09/11/15 at 9:57 PM with Nurse Aide (NA) #4, who worked also as a restorative aide, revealed Resident #56 often refused the palm guard but if she agreed, she would wear it about 2 hours. NA #4 stated the elbow splint was to be applied 6 times a week. She further stated she applied the elbow splint on Monday (09/07/15) and worked as a floor NA Tuesday (09/08/15) and was not sure if anyone else applied the elbow splint. She stated Monday was the last time she provided services to Resident #56. During observations on 09/11/15 at 10:15 AM, Resident #56 tolerated passive range of motion provided by NA #4, refused the palm guard but allowed the elbow splint to be applied. Telephone interview on 09/11/15 at 10:36 AM with NA #5, who worked as a restorative aide at times, revealed she last completed restorative duties a week and a half ago. She stated that she applied the elbow splint but did not know anything about the need for passive range of motion or a hand guard. She again stated she only applied the elbow splint but did not provide range of motion or palm guard. Telephone interview on 09/11/15 at 1:00 PM with NA #6, who worked as a restorative aide at times, revealed she knew to provide passive range of motion and apply the palm guard and elbow splint, but stated Resident #56 refused the palm guard. NA #6 stated the last time she worked with Resident #56 was last Saturday (09/05/15). She further stated that when she was assigned as a floor nurse aide, she did not provide restorative services. On 09/11/15 at 1:52 PM, Restorative Nurse stated the referral from therapy that she received instructed staff to complete range of motion and apply the splint. she provided a computerized Rehab Communications to Nursing form dated 05/06/15 stated that Resident #56 was discharged from therapy on 05/11/15 and to begin restorative nursing on 05/12/15. This form noted passive range of motion was to be provided to the left shoulder, elbow, wrist and fingers. Also checked was a splinting program but the section specifying the type of splint was left blank. The restorative program was to be provided 6 days per week and was signed by a rehab therapy aide. She further stated that when the referral did not specify what splint to use, she assumed it was the palm guard which was previously being used. She stated when she had provided restorative services (documented on 08/21/15 and on 09/07/15) she did not know an elbow splint was being utilized on Resident #56. Restorative nurse further stated she was not involved in the discharge instructions provided by therapy to the staff and just took the written information off the referral form when she developed the restorative plan of care.
F 0282 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident, family, and staff interviews, the facility failed to follow the care plan for providing incontinent care and oral care for 3 of 7 residents dependent on staff for activities of daily living (Residents #59, #92, and #11).

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0282 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) The findings included: 1) Resident #59 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set ((MDS) dated [DATE] indicated Resident #59 was severely cognitively impaired and required extensive assistance with dressing, toileting, personal hygiene, bathing, and was incontinent of bowel and bladder. Review of the care plan dated 07/20/15 revealed Resident #59 with urinary incontinence related to cognitive impairment with an intervention to provide incontinence/perineal care after each incontinent episode. On 09/10/15 at 11:35 AM Resident #59 was observed sitting in his room in a wheelchair with his pants visibly wet and a strong odor of urine. The resident stated I am wet and I need to go to the bathroom. On 09/10/15 at 12:30 PM an interview was conducted with Resident #59's family member. The family member stated she had asked staff for assistance to take Resident #59 to the bathroom around 12:00 PM and that no one had come to the room to assist them. On 09/10/15 at 12:45 PM Nurse Aide (NA) #3 was observed providing incontinent care in the bathroom for Resident #59 and NA #3 was observed to remove the urine soaked and slightly soiled brief, clean the resident's buttocks, while the resident was in a standing position using packaged pre-moistened wipes, apply a clean dry brief, and assist the resident back to his wheelchair. NA #3 was observed not to clean/wipe Resident #59's groin or penile areas. On 09/10/15 at 1:15 PM an interview was conducted with NA #3. NA #3 stated that was the way he had always provided incontinent care to Resident #59 while he was standing in the bathroom. NA #3 confirmed he had not cleaned the resident's penile area. NA #3 verbalized that he was expected to wipe the resident front to back and he was expected to clean the penile area of the male resident by pushing the foreskin back, cleaning/wiping in a circular motion, and pulling the foreskin back down. NA #3 stated he had not completed incontinence care for Resident #59 in the correct way he was trained. NA #3 gave no explanation as to why he provided incontinence care incorrectly and stated I do the best I can. On 09/11/15 at 7:35 AM Resident #59 was observed in his room, sitting in a recliner and his pants were down to mid-way of the thighs, no brief in place, the resident's pants was visibly soiled with urine and the pad in the recliner chair was soiled with urine and feces. On 09/11/15 at 8:17 AM NA #2 was observed providing incontinent care for Resident #59. NA #2 was observed to assist the resident to a standing position, wipe/clean the feces from the resident's buttocks, placed a clean dry brief, clean dry pants, and assist the resident into his wheelchair. NA #2 was observed not to clean/wipe Resident #59's groin or penile areas. On 09/11/15 at 8:30 AM an interview was conducted with NA #2. NA #2 confirmed he had not provided Resident #59's incontinence care correctly. NA #2 stated he was supposed to clean the resident's penis area before cleaning the buttocks. NA #2 stated he was trying to get the resident somewhat cleaned in order for Resident #59 to eat his breakfast meal before it got cold. NA #2 indicated he did not usually provide incontinence care incorrectly and stated I did the best I could for now. On 09/11/15 at 1:30 PM an interview was conducted with Nurse #2. She stated she expected the NAs to provide incontinence care as they were trained and their training would have included the cleaning of the perineum area. On 09/11/15 at 6:00 PM an interview was conducted with the MDS Nurse. She stated the NAs were trained to follow the resident's care guides. She explained the care plans were developed to meet the individual needs of the residents and the care guides were an extension of the care plan for the NAs to use and to know how to care for a resident. Resident #59's care guide was reviewed and it specified the resident required incontinent care. The MDS Nurse stated she expected the NAs to follow the care plans and that all the NAs were trained during orientation to follow the care plans/guides. On 09/11/15 at 8:00 PM an interview was conducted with the Director of Nursing (DON). She stated she expected the NAs to provide incontinence care to the residents as they had been trained and to have provided it correctly. 2) Resident #92 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set ((MDS) dated [DATE] was incomplete due to Resident #92 being a new admit but was coded as severe cognitively impaired and was totally dependent on staff for activities of daily living (ADLs). Review of the new admission care plan dated 09/04/15 indicated Resident #92 had inappropriate behaviors related to a physical and mental functioning deficit with an intervention for staff to anticipate and provide assistance with the resident's ADLs. Review of Resident #92's care guide dated 09/04/15 indicated the resident had inappropriate behaviors, exposed self, played in feces, and screamed out. The interventions included 2 person physical assistance with the resident's ADLs, to monitor resident frequently, and use non-pharmacological behavioral interventions. On 09/09/15 at 9:00 AM Resident #92 was observed with the door to the room opened, privacy curtain was pulled between the resident and the roommate, lying on her back, uncovered. Further observation of the resident revealed she had the right side of the brief un-taped, legs bent up and crisscrossed at the ankles, playing in her own feces. Resident #92 was observed to have feces on bilateral heels, right upper thigh, on the right hand and fingers, on the bed linens, and the mattress. On 09/09/15 at 9:15 AM Resident #92 was observed with the door to the room opened, the privacy curtain was pulled between the residents, lying on her back, uncovered, and the resident had the right side of the brief un-taped, legs bent up and crisscrossed at the ankles, with feces noted on the resident's heels bilaterally, on the right upper thigh, on the right hand and fingers, on the bed linens, and the mattress. On 09/09/15 at 9:30 AM, a staff member was observed to walk into the resident's room, pulled the curtain almost closed around the resident's bed/area, went up the hall and told Nurse #2 that Resident #59 had a bowel movement and was in need of assistance. Continuous observations of Resident #92 from 09/09/15 at 9:30 AM until 10:30 AM revealed staff walking up and down the hall and no one was observed to go into the resident's room. Resident #92 was observed to remain with the door opened to the room, the privacy curtain pulled between the resident's, lying on her back, uncovered, the right side of the brief un-taped, legs bent up and crisscrossed at the ankles, feces was noted on the resident's heels bilaterally, on the right upper thigh, the right hand and fingers, the bed linens, and mattress. On 09/09/15 at 10:30 AM Nurse Aide (NA) #6 and NA #4 were observed and gave Resident #92 a full bed bath, changed her gown, placed a clean brief, wiped down the mattress, and placed clean linens on the bed. On 09/09/15 at 1:00 PM an interview was conducted with NA #6. She stated she was expected to do 15 minute to 30 minute rounds on Resident #92. NA #6 further stated she had been very busy and had not checked on the resident since earlier in the morning. She indicated the NAs were expected to check on Resident #92 frequently which meant to her every 15 to 30 minutes. She further indicated she was very busy and was unaware the resident had been lying in feces for over an hour. On 09/09/15 at 1:30 PM an interview was conducted with NA #4. She stated she had been assigned to work the other hall and was asked by NA #6 to assist with bathing of Resident #92. NA #4 further stated she had not worked on the same hall as Resident #92 and was unaware of her care needs. NA #6 indicated the NAs were expected to make rounds on the residents every 2 hours and more frequently should it be necessary. She further indicated more frequently meant to check on a resident every 15 to 30 minutes. On 09/09/15 at 2:15 PM an interview was conducted with Nurse #2. She stated she expected the NAs to make rounds on the residents every 2 hours and more frequently if needed. She indicated more frequently in regards to Resident #92 would be every 15 minutes. Nurse #2 stated she did recall a staff member to inform her of Resident #92's care need and that she had become very busy and forgot to tell the NAs. Nurse #2 stated she was unware Resident #92 had laid in feces for more than an hour. On 09/11/15 at 6:00 PM an interview was conducted with the MDS Nurse. She stated the NAs were trained to follow the resident's care guides. She explained the care plans were developed to meet the individual needs of the residents and the care guides were an extension of the care plan for the NAs to use and to know how to care for a resident. Resident #92's care guide was reviewed and specified that the resident required monitoring frequently. The MDS Nurse stated she expected the NAs to follow the care plans and that all the NAs were trained during orientation to follow the care plans/guides. The MDS nurse confirmed that monitor frequently meant to check on a resident every 15 to 30 minutes. On 09/11/15 at 8:00 PM an interview was conducted with the Director of Nursing (DON). She stated she expected the NAs to frequently check on the residents and more frequently on Resident #92. The DON indicated she would have expected staff to have checked on the resident at least every 15 to 30 minutes. She stated she was unaware that Resident #92 had laid in

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	345219	A. BUILDING _____ B. WING _____	09/11/2015

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F 0282 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) feces for over an hour. 3) Resident # 11 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the annual Minimum Data Set ((MDS) dated [DATE] indicated Resident #11 had severe cognitive impairment and required extensive assistance with all activities of daily living (ADLs), to include personal hygiene, and the resident did not refuse care. Review of the care plan dated 07/20/15 revealed Resident #11 care deficit pertaining to the teeth or oral cavity characterized by dental health problems related to carious (tooth decay) teeth and poor oral hygiene with an intervention for staff to provide oral hygiene. On 09/10/15 at 3:20 PM Resident #11's teeth was observed coated with a thick accumulation of yellowish matter along the gum line of the top teeth and the teeth were visibly dirty. On 09/11/15 at 12:45 PM Resident #11's teeth was observed with a thick accumulation of yellowish matter along the gum line of the top teeth and the teeth were visibly dirty. On 09/11/15 at 1:00 PM an interview was conducted with Resident #11 and she was asked if staff helped her to clean her teeth and she answered, No. The resident explained that she had not had her teeth brushed in a long time and could not recall when the last time a staff member brushed her teeth. On 09/11/15 at 1:30 PM an interview was conducted with NA #1. She stated she was familiar with the resident and knew the resident's care needs. NA #1 explained that she was aware that Resident #11 required assistance with brushing her teeth but she was unable to recall the last time she had provided oral care for Resident #11. She confirmed that Resident #11 was in need of oral care and that it was also provided on the care guide for oral hygiene to be completed daily. On 09/11/15 at 1:45 PM an interview was conducted with NA #4. She stated she had worked at the facility a long time and was familiar with the care needs of Resident #11. NA #4 indicated she was aware that the resident was supposed to have oral care provided daily. NA #4 confirmed Resident #11 was in need of oral care but she was unable to recall the last time she had assisted the resident with her oral hygiene. On 09/11/15 at 2:30 PM an interview was conducted with Resident #11's family member. The family member indicated that Resident #11's teeth were not brushed daily and he had specifically asked for the resident to be provided oral care every day. The family member further indicated he expected Resident #11's teeth to be brushed at least daily. An interview was conducted with Nurse #2 on 09/11/15 at 3:45 PM. She stated it was her expectation for a resident's oral care be provided at least once daily. Nurse #2 confirmed the resident's oral care had not been provided. Nurse #2 further stated she expected the NAs to follow the resident's care guides and expected the care to be provided. On 09/11/15 at 6:00 PM an interview was conducted with the MDS Nurse. She stated the NAs were trained to follow the resident's care guides. She explained the care plans were developed to meet the individual needs of the residents and the care guides were an extension of the care plan for the NAs to use and to know how to care for a resident. Resident #11's care guide was reviewed and specified the resident's teeth were to be brushed daily by the nurse aide. The MDS Nurse stated she expected the NAs to follow the care plans and that all the NAs were trained during orientation to follow the care plans/guides. On 09/11/15 at 8:00 PM an interview was conducted with the Director of Nursing (DON). She stated she expected the NAs to follow the care plan/guides for each resident. The DON further stated she would have expected the NAs to have assisted and/or brushed Resident #11's teeth at least daily.
F 0311 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that residents receive treatment/services to not only continue, but improve the ability to care for themselves.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, resident interviews and staff interviews, the facility failed to assist with feeding 2 of 4 residents (Residents #5 and #25) sampled for requiring limited assistance with feeding. The findings included: 1. Resident #5 was admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. Her annual Minimum (MDS) data set [DATE] coded her with severely impaired cognitive skills, having appetite issues, and being independent with eating after set up. The Care Area assessment dated [DATE] for Nutritional Status stated Resident #5 ate in the dining room and required supervision and encouragement to finish meals. A care plan for the problem of requiring assistance to maintain maximum function of self sufficiency for eating related to requiring cueing and supervision to eat and finish meals was last reviewed on 08/10/15. Interventions listed included EATING: Provide constant encouragement remaining with resident during meals. A care guide located in her closet dated 08/11/15 noted staff was to provide constant encouraging, remaining with the resident during meals, she fed herself and needed assistance with eating as necessary. Continuous observations made on 09/10/15 starting at 8:24 AM revealed Resident #5 was in bed with her tray set up in front of her. At 8:24 AM, she was alone in the room and asleep with her untouched tray in front of her. At 8:29 AM Nurse #1, working on the hall as a nurse aide this date, looked into the room and passed by as the resident was sleeping and not eating. Nurse #1 continued to pass trays and again looked into the room without stopping as the resident remained sleeping. Then at 8:36 AM, Resident #5 started to feed herself. At 8:42 AM, Nurse #1 walked in and immediately walked out of the room while the resident was feeding herself. She did not intervene or talk to Resident #5. No staff was observed entering Resident #5's room as she fell back to sleep. By 9:24 AM, she was asleep and had only eaten a few bites of oatmeal, half of her ground meat, a bite of scrambled eggs and had drank her coffee but not her milk. At 9:26 AM, Nurse #1 passed the room looked in and did not stop to wake her up. Nurse #1 passed the room again at 9:42 AM and looked in but did not stop and the resident was still sleeping, At 9:51 AM, the Administrator passed the room, looked in and did not stop. At 9:52 AM, Nurse Aide (NA) #3 woke Resident #5 up, asked her if she needed anything else and if she was finished with her meal and took the tray away. Resident #5 had eaten approximately 25 percent of her meal. Resident #5 was observed alone in her room in bed on 09/10/15 at 12:17 PM when she was served her tray. Staff set the tray up and left her alone. She removed the straw from her supplement box, placed it in her chicken and tried to drink through the small opening of the box at 12:18 PM and at 12:23 PM. She remained alone in the room, not eating with the straw still in her chicken until 12:51 PM when the Director of Nursing sat and tried to assist and encourage her to eat. On 09/10/15 at 9:34 AM, Nurse #1 stated during interview that care guides were located in each residents' closet that specified individual resident care needs. On 09/10/15 at 2:42 AM, Nurse #1 was interviewed. She stated she looked in on the resident several times and entered once but did not stay. She stated Resident #5 could feed herself and staff needed to encourage her. When asked why she did not enter to assist, she stated she could do better next time. At this time NA #3 came up and stated Resident #5 needed help with feeding. Nurse #1 stated she was a nurse and was working as a NA today and seldom helped with feeding residents. Interview on 09/11/15 at 5:33 PM with the MDS nurse revealed she developed the care plans. She stated that if Resident #5 was left alone, she would be at risk for not completing her meal. She further stated the resident would sit and not eat so staff were to remain with the resident to give her cues to eat during meals. MDS nurse stated Resident #5 normally ate in the dining room where staff were present to give her cuing as needed. 2. Resident #25 was admitted to the facility on was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The admission Minimum Data Set coded him as being cognitively intact and requiring extensive assistance with eating. Resident #25 began occupational therapy on 05/11/15 with a goal to improve his self feeding abilities. A care plan was developed to address the requirement of assistance to maintain or restore his self sufficiency for eating. this care plan was last reviewed on 07/20/15. Interventions included to set up tray and EATING: Provide constant encouragement remaining with resident during meals. On 09/08/15 at 12:18 PM, Resident #25 was served his tray as he sat at the table with Resident #42. Upon the tray being placed in front of him, Resident #25 stated to the nurse aide (NA) who served him that she would have to cut up his meat (a beef patty). NA walked away without cutting up his meat. Resident #25 picked up his roll and started to feed himself. He exhibited very shaky hand tremors. Then he attempted to obtain his utensils which were rolled in a napkin on his tray. He tore the end of the napkin and pulled the fork out and began feeding himself. At 12:21 PM, Resident #42 started to feed Resident #25 beets. At 12:22 PM, NA #7 approached the table and stated she would help and proceeded to cut up his beef

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F 0311 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 9) patty and started feeding him. Once the NA fed him some beef he asked her to put a straw in one of his drinks. Once she put a straw in his tea, she got up and walked away. When she walked away, Resident #42 began to feed Resident #25 again. At 12:25 PM, NA #1 walked up and told Resident #42 that she could help feed Resident #25. Resident #42 stated he could do it as I do it all the time. NA #1 told him he was not supposed to feed other residents. Resident #25 was observed to pick up his meat with his hands, leaned forward to sip his drink through the straw and then NA #1 sat to feed him. On 09/08/15 at 12:37 PM, Resident #25 stated his tremors made it hard for him to hold a glass or a fork. He also stated his tablemate helps me a lot to eat. On 09/10/15 at 8:35 AM, Resident #25 was observed in bed, feeding himself breakfast despite his tremors. At 8:47 AM he had eaten almost 100 percent of his meal tray by himself. On 09/10/15 at 12:23 PM, Resident #25 was observed with chicken and pastry, peas in a plastic pliable cup, and juices. Resident #25 was observed eating peas from the cup in a drinking manner. NA #4 stated occupational therapy (OT) told her to put the peas in the cup. At 12:25 PM, the tablemate Resident #42 was observed holding the cup of juice which Resident #25 drank from as NA #4 sat nearby and watched. At 12:29 therapy left the dining room and Resident #42 provided a new juice with straw next to Resident #25 so he could drink more. At 12:32 PM, Resident #42 was observed feeding Resident #25 his chicken and pastry. NA #4 was sitting close by and was observed directly watching Resident #42 feed Resident #25. At 12:33 PM, NA #4 asked resident #42 if he needed help to feed Resident #25. Resident #42 stated no that he could do it as he did it all the time. NA #4 sat back down as Resident #42 continued to feed Resident #25. On 09/10/15 at 12:37 PM, NA #4 was interviewed. NA #4 stated her usual job was transporting residents to appointments. When asked about Resident #42 feeding Resident #25, NA #4 stated she was not sure about the arrangement for feeding, and stated Resident #42 told her he fed Resident #25 all the time. She further stated she was not sure if occupational therapy knew about Resident #42 feeding Resident #25. NA #4 stated as a NA she was trained to assist residents with feeding if they had trouble. She further started that she did not know if Resident #25 could feed himself as she was not usually assigned to work in the dining room. On 09/11/15 at 9:24 AM OT was interviewed. OT stated Resident #25's status fluctuated. Therapy had tried a variety of devices including weighted utensils, different cups and divided plate. Resident #25 preferred regular utensils and he got finger foods when available. She further stated that small items such as peas should be put in a plastic cups which he can handle independently and liked. OT stated she had educated staff several times about utilizing plastic cups for small items like peas but NA #4 did not know to try that with Resident #25. On 09/11/15 at 5:58 PM, MDS nurse who worked also as the restorative nurse was interviewed. She stated Resident #25 could feed himself and usually did not need assistance. MDS nurse stated that NA #4 should have sat and taken over assisting Resident #25 eat when she saw another resident feeding him.
F 0312 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Assist those residents who need total help with eating/drinking, grooming and personal and oral hygiene.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, family, resident, and staff interviews, the facility failed to provide personal hygiene for dependent residents in need of showering, shaving, oral care, and finger nail care for 5 of 8 residents reviewed for activities of daily living (Residents #92, #11, #59, #53, and #48). The findings included: 1) Resident #92 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set ((MDS) dated [DATE] was incomplete due to Resident #92 being a new admit but was coded as severe cognitively impaired and was totally dependent on staff for activities of daily living (ADLs). Review of the new admission care plan dated 09/04/15 indicated Resident #92 had inappropriate behaviors related to a physical and mental functioning deficit with an intervention for staff to anticipate and provide assistance with the resident's ADLs. An observation was made on 09/08/15 at 1:48 PM of Resident #92. The resident was noted to have brown debris underneath the index finger, ring finger, and the middle finger of the right hand. An observation was made on 09/09/15 at 9:40 AM of Resident #92. The resident was noted to be lying in bed, uncovered, with her legs crisscrossed up in the air, and brown dried substance was observed on the resident's upper left thigh area and the right hand was also noted to have brown debris underneath the index, middle, ring, and pinky fingers. An observation was made on 09/10/15 at 11:25 AM of Resident #92. The resident was observed lying in bed, uncovered, with her legs crisscrossed up in the air, and was observed to be playing in her own feces with her right hand. The resident's door was opened to the room and the privacy curtain was pulled and the resident was unable to be viewed from the hallway. An observation was made on 09/10/15 at 12:54 PM of Nurse #1 and Nurse Aide (NA) #3 provided incontinent care for Resident #92. They were observed to wash, clean, and changed the resident's gown, changed the bed linens, and washed the resident's hands. NA #3 was interviewed on 09/10/15 at 1:15 PM. NA #3 stated Resident #92 was a difficult resident to care for and they did the best they could with the resident. NA #3 indicated they always tried to keep the residents clean and dry but it was impossible to complete all care such as assisting residents to the toilet, shaving, oral care, showers, making and changing beds. NA #3 reported some residents had to wait long periods of time to be changed when wet, soiled, or taken to the toilet due to the facility being short staffed. Nurse #1 was interviewed on 09/10/15 at 1:25 PM. Nurse #1 stated she was assisting on the hall today in the capacity of a Nurse Aide due to the hall being short staffed. She further stated the NAs could not keep the residents clean, dry, complete showers, and the ADLs were not getting done due to lack of staffing. Nurse #1 reported that the nurses have had to work as NAs at least 1 to 2 days a week in the past 3 months due to the facility being short staffed. An observation was made on 09/11/15 at 1:00 PM of Resident #92. The resident was noted to have brown dried debris around the nail bed and underneath the index, ring, and middle fingers of the right hand. The resident was also observed to put the index finger of the right hand into her mouth. An observation was made on 09/11/15 at 1:10 PM of NA #1 and NA #4 provided care for Resident #92. The NAs provided incontinent care, washed the resident's hands, and was observed to not clean around the nail beds or underneath the fingernails of the right hand while care was provided. An interview was conducted on 09/11/15 at 1:30 PM with NA #1. She stated it was almost impossible to complete all care such as showers, nail care, shaving, oral care, and making and changing of bed linens. She indicated as short staffed as they were they focused on toileting, changing, and feeding of the residents and the other care needs were completed on days if there were any extra staff working. She further stated she had washed the resident's hands and was unaware there was brown debris around or underneath the resident's nails. An interview was conducted on 09/11/15 at 1:45 PM with NA #4. She stated she worked as a nurse aide on whichever hall was short staffed for that day and that resident care needs such as showers, nail care, oral care and shaving were not provided on a scheduled weekly basis. She indicated when she worked as a float NA she would be assigned to give resident showers but for the last 2 to 3 months she had worked as a regular staff and not as a float NA. She further stated she was unaware of the brown debris underneath the resident's nails and that NA #1 had washed the resident's hands. An interview was conducted with Nurse #2 on 09/11/15 at 3:45 PM. She stated nail care and shaving was provided by the NAs on shower days and that oral care was to be provided on a daily basis. She revealed showers, nail care, shaving, or oral care was rarely done for residents and some residents had to wait long periods of time to be changed when wet due to the facility being short staffed. Nurse #2 confirmed the brown debris around and underneath Resident #92's nails on the right hand and Nurse #2 was observed to clean the resident's nails. An interview was conducted with the Director of Nursing (DON) on 09/11/15 at 8:00 PM. She stated it was her expectation that all care should be provided to the resident and if certain care areas were missed they should be reported for the next shift to be done. The DON further stated she would have expected the resident's nails to have been cleaned and with no visible signs of brown debris. The DON further stated she did not know what needs were not being met. 2) Resident #11 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set ((MDS)

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F 0312 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 10) dated [DATE] indicated Resident #11 had severe cognitive impairment and required extensive assistance with all activities of daily living (ADLs) and was totally dependent on staff for bathing. Review of the care plan dated 07/20/15 revealed Resident #11 had a physical functioning deficit related to self-care impairment, mobility impairment with an intervention for staff to assist with activities of daily living (ADLs) to include oral care, shaving, combing hair, washing of face and hands, feeding, oxygen therapy via nasal cannula (NC), and call light within reach at all times. An observation of Resident #11 on 09/10/15 at 3:20 PM revealed resident's teeth were coated with yellowish/brownish film, wearing a purple colored shirt, and the resident's hair to be greasy looking. Resident #11 was observed on 09/11/15 at 12:45 PM wearing a purpled colored shirt with dried brown stains on the front, hair greasy in appearance, and the resident's teeth were observed with a yellowish film. These same observations were noted on 09/11/15 at 1:10 PM, on 09/11/15 at 1:30 PM, on 09/11/15 at 1:45 PM, and on 09/11/15 at 2:30 PM. An interview was conducted on 09/11/15 at 1:30 PM with NA #1. She stated the NAs worked short staffed most days and they no longer had a shower team. She further stated it was almost impossible to complete all care sure as showers, nail care, shaving, oral care, and making and changing of bed linens. She indicated the NAs were focused on toileting, changing, and feeding of the residents and there was not enough time to complete the other resident care needs. An interview was conducted on 09/11/15 at 1:45 PM with NA #4. She stated she worked as a nurse aide on whichever hall was short staffed for that day and that resident care needs such as showers, nail care, oral care and shaving were not provided on a scheduled weekly basis. She indicated when she worked as a float NA she would be assigned to give resident showers but for the last 2 to 3 months she had worked as a regular staff NA and not as a float NA. On 09/11/15 at 2:30 PM an interview was conducted with Resident #11's family member. The family member observed the resident's oxygen tubing lying in the floor and he was observed to pick up the oxygen tubing and placed it into the resident's nose. The family member stated the facility was short staffed and was unable to keep staff employed. The family member further stated he seldom missed a day visiting the resident because she rarely ever left the room and that the staff were not providing the care to the residents as expected. The family member indicated that Resident #11's teeth were not brushed daily, her clothes were not changed every day unless he would asked them to change her, and that the resident was not being provided with showers. The family member further indicated there was no continuity of care and he expected the resident's face to be washed every morning, her clothes to be changed daily or more frequently if soiled, her teeth brushed at least daily, and a shower with her hair washed 2 times a week. The family member reported he had talked with the Director of Nursing (DON) several times in regards to his expectations and the care would get better for a little while and then the resident's care would start to decline again. An interview was conducted with Nurse #2 on 09/11/15 at 3:45 PM. She stated it was her expectation for a resident's oral care be provided at least once daily, and nail care and shaving was provided by the NAs on shower days. Nurse #2 confirmed the resident's oral care had not been provided. She reported due to working short staffed the NAs had not had time to provide Resident #11's oral care today. She revealed showers, nail care, shaving, or oral care was rarely done for residents and some residents had to wait long periods of time to be changed when wet due to the facility being short staffed. An interview was conducted with the Director of Nursing (DON) on 09/11/15 at 8:00 PM. She stated it was her expectation that all care should be provided to the resident and if certain care areas were missed they should be reported for the next shift to be done. The DON further stated she did not know what needs were not being met. 3) Resident #59 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set ((MDS) dated [DATE] indicated Resident #59 was severely cognitively impaired and required extensive assistance with dressing, toileting, personal hygiene, bathing, and was incontinent of bowel and bladder. Review of the care plan dated 07/20/15 revealed Resident #59 was at risk for falls and had a physical functioning deficit related to self-care impairment with an intervention for staff to assist with activities of daily living (ADLs). An observation of Resident #59 on 09/10/15 at 11:35 AM revealed the resident setting in a wheelchair with soiled pants. An interview was conducted on 09/10/15 at 12:30 PM with Resident #59's family member. The family member stated she had asked staff for assistance to take Resident #59 to the bathroom around 12:00 PM and that no one had come to the room to assist them. The family member further stated it usually took at least 30 minutes or longer for staff to assist the resident. An observation on 09/10/15 at 12:45 PM of Nurse Aide (NA) #3 and Nurse #1 come into Resident #59's room and provided incontinent care. An interview was conducted on 09/10/15 at 1:15 PM with NA #3. NA #3 stated the NAs worked short staffed most days. NA #3 stated with 2 NAs on the hall it was impossible to complete all care such as assisting residents to the toilet, shaving, oral care, showers, making and changing beds. NA #3 reported some residents had to wait long periods of time to be changed when wet or taken to the toilet due to the facility being short staffed. An interview was conducted on 09/10/15 at 1:25 PM with Nurse #1. She stated she was assisting on the hall today in the capacity of a Nurse Aide due to the hall being short staffed. She further stated the NAs could not keep the residents clean, dry, complete showers, and the ADLs were not getting done due to lack of staffing. Nurse #1 reported that the nurses have had to work as NAs at least 1 to 2 days a week in the past 3 months due to the facility being short staffed. An observation on 09/11/15 at 7:35 AM revealed a strong odor of urine upon entering the resident's room and Resident #59 was sitting in a recliner, pants were down to mid-way of the thighs, no brief in place, and the resident's pants visibly soiled, and the pad in the chair was soiled also. The resident stated I am so wet can you please help me. The resident's call light was observed to be lying behind the resident's recliner and not within the resident's reach. NA #2 was observed on 09/11/15 at 8:17 AM to wipe the resident's buttocks, changed the brief, and put dry, clean pants on Resident #59. NA #2 was further observed to assist the resident to the wheelchair and setup his breakfast tray on the over-bed table. An interview was conducted on 09/11/15 at 8:30 AM with NA #2. NA #2 stated the 3rd shift NA had not made rounds and cleaned/dried the residents before the breakfast trays had come to the hall. NA #2 reported there was only 1 NA after 3:00 AM for the hall and that it was impossible for the residents to be changed, cleaned, dried, and be gotten up before 1st shift come in and/or the breakfast trays come to the hall. NA #2 further stated the NAs do the best they can and that it was impossible to complete the resident's care such as showers, oral care, and shaving due to the facility being short staffed. An interview was conducted with the Director of Nursing (DON) on 09/11/15 at 8:00 PM. She stated it was her expectation that all care should be provided to the resident and if certain care areas were missed they should be reported for the next shift to do. The DON further stated she did not know what needs were not being met. 4. Resident #53 was admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. The annual Minimum (MDS) data set [DATE] coded him with moderately impaired cognition, having no behaviors, being nonambulatory, and requiring extensive assistance with hygiene. The activities of daily living Care Area assessment dated [DATE] stated he required staff assistance A care plan was developed related to the need for assistance for self sufficiency for personal hygiene to maintain his daily appearance. The care plan was last reviewed on 08/10/15 and had a goal to be neat, clean and odor free. Interventions included constant supervision with physical assist with combing hair, shaving and brushing teeth. a. Resident #53 was observed on 09/08/15 at 11:48 AM with a heavy growth of beard several days old on the sides of his face and neck. He remained unshaven on 09/08/15 at 3:00 PM, on 09/09/15 at 7:50 AM and on 09/09/15 at 8:05 AM. On 09/09/15 at 8:05 AM he stated he liked to shave every other day. He continued to be unshaven when observed on 09/10/15 at 8:33 AM, at 9:43 AM, at 10:25 AM, and at 11:39 AM; on 09/11/15 at 7:30 AM, at 10:30 AM, and at 1:31 PM. b. Resident #53 was observed to have long fingernails, extending about an eight of an inch beyond the end of his fingers on both hands which had brown debris under the nails on 09/09/15 at 7:51 AM and 09/11/15 at 7:30 AM. Interview with nurse aide (NA) #1 revealed Resident #53 will go to the shower twice a week. She stated she shaved him and did his nails last week but did not have him in her care this week. Interview with NA #8 on 09/11/15 at 2:19 PM, who was responsible for Resident #53 this date stated that Resident #53 will often refuse care which will be reflected in the kiosk documentation. NA #8 stated that nurse aides are not permitted to cut toenails or fingernails of residents with diabetes.

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	345219	A. BUILDING _____ B. WING _____	09/11/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0312 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 11) On 9/11/15 at 2:27 PM, Director of Nursing (DON) stated that nurses provide all nail care for residents with diabetes and nurse aides completed shaving and cleaned the nails usually on shower days or with bed baths. On 09/11/15 at 2:55 PM Nurse #2 stated shaving and nail care was provided by nurse aides on shower days. She stated she had never been told she was responsible for nail care for residents with diabetes. At this time we looked at his nails together. Nurse #2 confirmed that all fingernails were soiled and needed trimming. At this time his toenails were also observed and noted to have 4 toenails on each foot with long nails extending beyond the toes. The toenails on the great toes were long and jagged. According to the shower schedule, Resident #53 was to be showered on Tuesday and Thursday. Per the nurse aide documentation, Resident #53 was showered on Saturday 09/05/15 and 09/07/15 and had a full bed bath on 09/09/15. 5. Resident #53 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the most recent annual Minimum Data Set ((MDS) dated [DATE] indicated Resident #53 was moderately impaired in cognition for daily decision making. The MDS indicated Resident #53 required extensive assistance with activities of daily living, did not exhibit behaviors of rejecting care and was always incontinent of bladder and bowel A review of a care plan titled urinary incontinence which was revised on 08/10/15 indicated Resident #53 had urinary incontinence. The goal was for Resident #53 to be free of skin breakdown through next review and the interventions included in part to provide pericare after each incontinent episode. During an observation on 09/10/15 at 10:28 AM Nurse #1 and Nurse Aide (NA) #3 provided incontinence care to Resident #53 as he lay in bed on his back. Nurse #1 removed a gauze sponge and wiped an opening in Resident #53's abdomen with perineal wipes. Nurse #1 stated the opening was for a catheter that Resident #53 used to have in place but the catheter had been removed and urine drained intermittently from the opening. Nurse #1 took a perineal wipe and wiped across the top of Resident #53's pubic area and inside the top of each groin but did not clean Resident #5's penis or scrotal area. Resident #53 was turned to his left side and a brief that was wet with urine was removed from under Resident #53. NA #3 took a perineal wipe and wiped Resident #53's buttocks and placed a clean brief under Resident #53 and fastened it and a sheet was pulled up over him and Nurse #1 and NA #3 removed their gloves, washed their hands and walked out of the room into the hallway. During an interview on 09/10/15 at 10:38 AM Nurse #1 explained she was assigned to work as a NA today to fill in for staff vacancies. She confirmed she did not clean Resident #53's penis because he often refused care and so she wiped him off as best as she could like she usually did. NA #3 then stated they did not have a lot of time to spend with residents so they did the best they could for Resident #53. During an interview on 09/11/15 at 5:47 PM with the MDS nurse she explained the opening in Resident #53's abdomen leaked urine but he also had urinary output from his penis and was incontinent of bladder and bowel. During an interview 09/11/15 at 5:40 PM with the Director of Nursing she stated it was her expectation for staff to clean Resident #53 thoroughly during incontinence care and that included cleaning the entire perineal area when they provided incontinence care for him. She stated she expected for residents to be cleaned thoroughly to prevent skin breakdown and odors. She further stated it was her expectation that perineal care would be given after each incontinent episode. 6. Resident #48 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the most recent quarterly Minimum (MDS) data set [DATE] indicated Resident #48 was moderately impaired in cognition for daily decision making. The MDS also indicated Resident #48 required supervision and set up for hygiene but she required extensive assistance with bathing. A review of a care plan dated 08/11/15 indicated Resident #48 required assistance to restore or maintain maximum function for bathing related to impaired function. The interventions indicated for 1 staff to provide physical assistance. During an observation on 09/08/15 at 03:01 PM Resident #48 was sitting up in bed with long black facial hairs on her upper lip and in the right corner of her mouth that were approximately ¼ inch long. During an observation on 09/09/15 at 8:41 AM Resident #48 was lying in bed with long black facial hairs on her upper lip and in the right corner of her mouth. During an observation on 09/10/15 at 3:10 PM Resident #48 was lying in bed with long black facial hairs on her upper lip and in the right corner of her mouth. During an observation and interview on 09/11/15 at 12:53 PM Resident #48 was sitting in bed in her room with long black facial hairs on her upper lip and in the right corner of her mouth. She stated sometimes she had tried to shave herself but she had trouble holding the razor or seeing the facial hair to cut it. She stated staff had shaved her facial hair at times when she got a shower or bath but they had not done it in a while. She further stated she would like to have the facial hair shaved because she didn't think she could do it by herself. During an interview on 09/11/15 at 1:01 PM with Nurse Aide (NA) #11 she explained they had to encourage Resident #48 to take a shower and if she wanted anything shaved they did it for her. She confirmed Resident #48 had facial hair that needed to be shaved and stated Resident #48 probably had a shower on Tuesday 09/08/15 on first shift but it did not look like she had been shaved on her shower day. During an interview on 09/11/15 at 1:01 PM with Nurse #1 she confirmed Resident #48 had a shower on Tuesday 09/08/15 but she had facial hair that needed to be shaved. She explained the Nurse Aides (NAs) were supposed to report to the nurse if they could not provide care to a resident or if the resident refused care or exhibited behaviors and would not let staff provide care to them. She stated she had not received any reports of Resident #48 refusing to have her facial hair removed. During an interview 09/11/15 at 2:28 PM the Director of Nursing stated NAs usually shaved residents when they had their bath or shower. She stated she expected for staff to shave them when they had a bed bath or shower and if the resident refused they should report it to the nurse.
F 0314 **Level of harm -** Actual harm **Residents Affected -** Few	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and physician and staff interviews the facility failed to assess skin integrity, prevent reoccurrence of a stage 4 pressure ulcer that developed in the facility and failed to provide wound treatments as ordered from a wound clinic physician for 1 of 3 residents sampled for pressure ulcers. (Resident #53). The findings included: Resident #53 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the most recent annual Minimum Data Set ((MDS) dated [DATE] indicated Resident #53 was moderately impaired in cognition for daily decision making. The MDS indicated Resident #53 required extensive assistance with activities of daily living and was at risk for development of pressure ulcers. A review of physician's orders [REDACTED]. Change dressing daily and as needed [MEDICATION NAME](antibiotic) 500 milligram by mouth twice daily for 2 weeks for wound infection. A review of a Wound Ulcer Flow sheet dated 07/30/15 at 2:10 PM indicated a stage 4 pressure ulcer on Resident #53's coccyx that occurred in facility with measurements of 1.0 centimeter (cm) length x 1.2 cm width x 0.3 cm depth with a small amount of drainage. The wound bed appearance was a small round open area at right of tail bone with a small amount of bone exposure noted and physician was notified. A review of treatment records revealed there was no documentation of pressure ulcer treatments for July 2015. A review of physician's orders [REDACTED]. A review of documents dated 08/05/15 from a wound center titled Discharge Instruction Details indicated Resident #53 had a stage 4 pressure ulcer on his coccyx. A section labeled primary wound dressing indicated [MEDICATION NAME] Alginate (for moderate to heavily draining wounds) on top of wound but not inside, 4x4 [MEDICATION NAME] border dressing, skin prep on intact skin around wound bed and change daily and as needed and barrier cream to anal and perineal area to reduce excoriation of skin. A review of a Wound Ulcer Flow sheet dated 08/06/15 indicated a stage 4 pressure ulcer on Resident #53's coccyx with

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F 0314 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 12) measurements of 1.0 cm length x 1.1 cm width x 0.3 cm depth with a pin point piece of tail bone exposed with redness around the wound. The document further revealed the current wound treatment was Silver Alginate (used for infection) to wound and Prostat (protein powder) by mouth for wound healing. A review of a care plan dated 08/10/15 revealed Resident #53 was at risk for skin break down or development of pressure ulcers related to impaired mobility. The goals indicated Resident #53 would not develop a pressure ulcer and the interventions were if nutritional status deteriorated to arrange a dietary consult, inspect skin and notify nurse of abnormal changes per facility protocol and provide incontinence and perineal care after each incontinent episode. A review of documents dated 08/12/15 from a wound center titled Discharge Instruction Details indicated Resident #53 had a wound on his coccyx, use [MEDICATION NAME] Alginate on top of wound but not inside, place 4x4 gauze dressing and [MEDICATION NAME] border dressing on top of wound, may use skin prep on intact skin around wound bed, change dressing daily and as needed for soiling and may use barrier cream to anal and perineal area to reduce excoriation of skin. The notes further indicated instructions for off-loading to not sit for long periods of time and when sitting to shift from side to side at intervals to relieve pressure, provide a thick gel pad for wheel chair and Resident #53 did not need to be up more than 1 hour if he was up out of bed, continue to use air mattress, turn resident every 1-2 hours and as needed for any redness and have a dietician assess nutritional status and treat accordingly with protein for stage 4 pressure ulcer. The document revealed wound measurements were 0.7 cm length x 0.4 cm width x 1.9 cm depth. A review of a facility document dated 08/15/15 titled Norton Scale for Predicting Risk of Pressure Ulcer (quarterly review) indicated Resident #53's physical condition was fair with limited mobility, incontinent of bladder and bowel and received current treatments of Silver Alginate to a wound on coccyx. The document indicated in part Prostat, air mattress, turn and reposition, a high density foam/gel cushion for chair and barrier cream at bedside. A review of treatment records revealed there was no documentation of treatments on 08/15/15. A review of a Wound Ulcer Flow sheet dated 08/17/15 at 10:11 AM indicated a stage 4 pressure ulcer on Resident #53's coccyx that occurred in facility with measurements of 0.5 cm length x 0.4 cm width x 0.2 cm depth with tunneling and undermining. A review of treatment records revealed there was no documentation of treatments on 08/23/15 or 08/24/15. A review of a Wound Ulcer Flow sheet dated 08/25/15 at 4:10 PM indicated a stage 4 pressure ulcer on Resident #53's coccyx with measurements of 0.5 cm length x 0.5 cm width x 0.1 cm depth with a small pin point open area to sacrum with non-visible wound base. A review of treatment records revealed there was no documentation of treatments on 08/30/15. A review of a nurse's note dated 08/31/15 at 3:48 PM documented by the treatment nurse indicated wound to coccyx was resolved. A review of a physician's orders [REDACTED]. A review of documents dated 09/02/15 from a wound center titled Discharge Instruction Summary indicated Resident #53 had a stage 4 pressure ulcer on his sacrum with measurements of 8.0 cm length x 4.7 cm width x 2.0 cm depth. A section labeled primary wound dressing indicated [MEDICATION NAME] Alginate on top of wound but not inside, sacral border dressing, skin prep on intact skin around wound bed and change daily and as needed for soiling and barrier cream to anal and perineal area to reduce excoriation of skin. A review of a treatment record dated 09/02/15 through 09/08/15 revealed there were no treatments documented for a pressure ulcer. During an interview on 09/09/15 at 9:37 AM with Nurse Aide (NA) #10 she stated there was redness on Resident #53's buttocks but he went to the wound clinic and all they had to do was to keep him clean and dry. She stated she was not aware of any barrier cream for Resident #53's skin on his buttocks. During an observation and interviews on 09/09/15 at 10:12 AM the Director of Nursing (DON) and treatment nurse entered Resident #53's room and the treatment nurse stated she had received a skin referral to evaluate Resident #53's sacrum. Resident #53 was turned to his left side and the treatment nurse removed an adhesive dressing from Resident #53's sacrum and there was a large open area that was dark in the center of the wound with raw skin around the edges with skin peeled back and an open hole at bottom of wound. The treatment nurse measured the wound and stated the wound was 10 cm length x 8.5 cm width x 1.2 cm depth and was unstageable because she could not see the wound bed. The DON stated staff were supposed to check Resident #53's skin on his shower days and if they saw skin problems they were supposed to report it to the nurse. She further stated Resident #53 did not like to turn off his back and frequently he slid down in bed with his bottom in a depression that was caused by a fold in the air mattress when the head of the bed was raised. The treatment nurse explained Resident #53 looked like he was sitting in a ditch when he slid down into the crease of the mattress and he would not reposition himself. She stated she was very surprised to see the pressure ulcer on Resident #53's sacrum and thought when staff had pulled him up in bed they had sheared the skin off his bottom and now the skin had dried out and had eschar (dead tissue). She further stated Resident #53 had previously had a stage 4 pressure ulcer on the right side of his sacrum that had a small hole with exposed bone but it was not in the same location as the current pressure ulcer. During an interview on 09/10/15 at 10:38 AM Nurse #1 explained she was assigned to care for Resident #53 last week and she stated she remembered his bottom was red but did not remember anything else about his skin. She stated she might have put a dressing on his bottom since it was red but could not remember exactly what she did. She further stated she was not aware of treatment orders from the wound clinic on 09/02/15 and had not received reports from other nurses that Resident #53 had a new pressure ulcer or had new treatment orders from the wound clinic on 09/02/15. During an interview on 09/10/15 at 10:38 AM with NA #3 he stated he tried to do the best he could can for Resident #53 but it was a challenge to keep him off his back. He explained sometimes he was the only NA on the hall and he had difficulty making his routine rounds to reposition Resident #53. During an observation on 09/10/15 at 12:15 PM Resident #53 was in bed with the head of the bed raised and was flat on his back with his bottom down in the depression in the fold of an air mattress which was set on a low pressure setting at a control unit located on the footboard of the bed. During an interview on 09/10/15 at 12:25 PM with the Physician's Assistant she stated it was her expectation for nursing staff to assess resident's skin and let her or the physician know if there were problems or issues. She explained nursing staff could call anytime 24 hours a day or they could leave a note in the physician's communication book and they would see residents when they made rounds. She further stated if a wound was worse or looked infected they should let her or the physician know about it. She explained she felt wound treatments were not always provided consistently and she was not always informed about wounds that needed treatment. She stated staff in the facility were their eyes and ears and staff had to tell her or the physician when something needed to be addressed. She explained she had made rounds in the facility on 09/07/15 but she did not see Resident #53 because she was not aware he had a wound on his sacrum. She further stated she expected staff to turn and reposition Resident #53 even if he did not want to turn to keep him off his bottom to prevent skin breakdown. During an observation on 09/10/15 at 3:04 PM Resident #53 was lying flat on his back with the head of the bed up with his bottom down in the depression in the fold of the air mattress. During an observation on 09/10/15 at 5:39 PM Resident #53 was lying flat on his back in bed with the head of the bed up with his bottom down in the depression in the fold of the air mattress. During a telephone interview on 09/11/15 at 9:11 AM with the wound care physician he confirmed he had seen Resident #53 earlier that morning and he had a big wound on his sacrum that had to debrided (surgical removal) of necrotic (dead) tissue. He stated he was very surprised to see the condition of the wound since Resident #53 had a healing wound when he was seen in the wound clinic in August. He further stated he could not remember specifics about the wound because he did not have the resident's chart in front of him but the nurse would provide the information. He explained he had ordered wet to dry dressings on Resident #53's wound since he had removed dead tissue from it that morning and it was his expectation for dressings to be changed as ordered, turn and reposition Resident #53 and provide an air mattress to relieve pressure. He further stated pressure should be avoided to promote wound healing. During an interview on 09/11/15 at 9:58 AM with a facility transporter who also was a Nurse Aide (NA) she verified she had transported Resident #53 to the wound clinic earlier that morning and she stayed with the resident in the treatment room when he saw the wound physician. She stated Resident #53 had a large wound on his bottom that did not smell good and it looked worse than the previous time she had transported him to the wound clinic on 09/02/15. She stated prior to that on 08/30/15 the wound on his bottom was looking really good. She further explained the wound clinic usually sent paperwork

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F 0314 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 13) back with the resident to the facility and she gave the paperwork to the nurse. During a follow up interview on 09/11/15 at 10:32 AM with the treatment nurse she explained she saw Resident #53's skin on 08/31/15 and the pressure ulcer she had been treating on his coccyx had healed and was pink with scar tissue. She stated she called the nurse practitioner who discontinued the treatment orders and she called the wound clinic to tell them the pressure ulcer had healed. She explained she did not realize Resident #53 went to his scheduled appointment at the wound clinic on 09/02/15 because no one had told her he had gone or that he had a new pressure ulcer until she got a skin referral on 09/09/15 and saw Resident #53 on 09/10/15. She confirmed the dressing she removed on 09/10/15 was a [MEDICATION NAME] sacrum border dressing but she did not know how long the dressing had been on the resident or who had put the dressing on because staff did not initial dressings with a date when a dressing was applied. She stated the facility had used staff from other facilities to fill in vacant positions and it was possible staff had not done treatments since they were not always familiar with residents or routines. She explained staff should turn and reposition Resident #53 to alleviate the pressure but it was a challenge because he preferred to lay on his back and did not like to turn or get out of bed. She further explained the new pressure ulcer on his sacrum looked like his skin had been sheared off when he had been pulled up in bed. She confirmed she was the wound treatment nurse in the facility but had also been assigned to work as a nurse on the halls to fill in for vacancies so she had to rely on nurses to let her know if resident's had red or broken areas of skin. She explained it was her expectation for staff to put a skin referral in the computer if a resident had skin breakdown so that she could assess them. She stated nurses had access to dressings and wound supplies and when she was not on duty they should have done treatments and should have told her about Resident #53's new pressure ulcer. She explained, after review of Resident #53's treatment records, there were no treatments documented for Resident #53's pressure ulcer from 09/02/15 through 09/08/15 because there was no documentation of Resident #53's clinic visit notes or orders in his medical record She explained usually the transporter brought back paperwork from the wound clinic and gave it to a nurse but she did not know if it was lost or what had happened. She verified nurses were supposed to write their initials on the treatment record when they provided treatments but since there were no initials the treatments were probably not done. She explained since she had not seen the wound clinic notes dated 09/02/15 other nurses were probably not aware of the treatment orders either and that could explain why treatments weren't done. During a telephone call on 09/11/15 at 11:00 AM from a nurse at the wound center she reported the following clinic visits for Resident #53: 09/02/15 wound measurements 8.0 cm length x 4.7 cm width x 2.0 cm depth with treatment of [REDACTED]. 09/11/15 wound measurements 11.7 cm length x 9.0 cm width x 2.3 cm depth with treatment of [REDACTED]. During an interview on 09/11/15 at 5:40 PM the DON stated it was her expectation for the transporter to bring orders from the wound clinic to the nurse when a resident returned to the facility. She further stated the nurse assigned to the resident needed to review the orders and the treatment nurse needed to review the orders and follow through with the treatment orders. She stated they needed to improve the communication system and if the nurse was not available when the transporter brought the resident back to the facility or the treatment nurse was not available the documents should be given to the DON. She confirmed there was no system for weekly skin checks but they needed a better system for skin assessments and skin referrals. She stated it was her expectation for treatments to be done daily or as ordered by the physician and if there was no treatment nurse on duty the nurse assigned to the resident should do the treatments. She further stated if there were no staff initials on the treatment records she interpreted it as the treatment was not provided.
F 0318 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that residents with reduced range of motion get propertreatment and services to increase range of motion.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, resident and staff interviews, the facility failed to provide an elbow splint and range of motion to 1 of 3 residents sampled for contractures with the restorative program established by the skilled therapy department (Resident #56). The findings included: Resident #56 was admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. Resident #56 began occupational therapy (OT) on 03/12/15 due to a contracture of the left elbow resulting in episodes of skin breakdown. The resident was noted to require skilled therapy and splint treatment to improve elbow contracture and decrease further risk of contracture. The annual Minimum Data Set ((MDS) dated [DATE] coded Resident #56 with intact cognition (scoring a 13 out of 15 on the Brief Interview for Mental Status), having no behaviors, requiring extensive assistance for most activities of daily living skills (ADLs), having range of motion limitation on one side of her upper extremities, and receiving skilled OT. OT's discharge summary dated 05/11/15 stated nursing staff (2 names) and restorative care staff (1 name) were trained in range of motion to the left upper extremity and the application of the palm guard and the static progressive splint. The discharge plan and instructions stated nursing and restorative care staff were to perform daily left upper extremity passive range of motion and splint application. The quarterly MDS dated [DATE] coded Resident #56 with intact cognition (scoring a 13 out of 15 on the Brief Interview for Mental Status), had no behaviors, requiring extensive assistance for most activities of daily living skills (ADLs), having range of motion limitation on one side of her upper extremities, and receiving no skilled therapy or any restorative nursing program including splinting. The current care plan which addressed Resident #56 being at risk for the development of further contractures was last reviewed on 07/20/15. The interventions included the resident was to wear a palm guard to the left hand 2-3 hours per day or as she tolerated after hygiene to palm had occurred 4 to 6 days a week. There was no plan including a static progressive elbow splint. Resident #56 was observed with her left elbow joint tucked in close, with elbow splint in place on 09/08/15 at 11:16 PM and on 09/10/15 at 8:16 AM, at 9:29 AM, at 10:51 AM, and at 11:39 AM. The elbow splint was located on the unoccupied bed in the room. At 11:39 AM, the responsible party was visiting and stated she was unsure if the splints were still being applied as she had not seen them on Resident #56 in a while. Resident #56 stated at this time the staff stopped applying the splints a while ago, admitting they hurt her. The elbow splint remained off when Resident #56 was observed on 09/10/15 at 2:51 PM. At this time, Nurse Aide (NA) #3 stated he was not sure about splint application and thought that restorative may do something. Interview with the Restorative nurse on 09/10/15 at 2:54 PM revealed Resident #56 was supposed to have a palm guard in place 2 to 3 hours per day as tolerated. She stated she received referrals from therapy. On 09/11/15 at 9:14 AM, the OT stated Resident #56 was to wear an elbow splint 6 days per week. OT was unaware of any refusals by the resident or problems with elbow splint. A handwritten Rehab communication to Nursing referral noted passive range of motion was to be provided to the left shoulder, elbow, wrist and fingers and a left elbow splint was to be placed four hours per day or overnight 6 days a week to maintain current range of motion to protect skin. This was noted to begin on 05/12/15 and was signed by the OT and by NA #1. Review of the documentation of passive range of motion and splint application revealed NA #1 who was trained in the elbow splint application had not provided restorative care to Resident #56 from 08/01/15 through 09/11/15. Interview on 09/11/15 at 9:57 PM with Nurse Aide (NA) #4, who worked also as a restorative aide, revealed Resident #56 was to wear the elbow splint 6 times a week. She further stated she applied the elbow splint on Monday (09/07/15) and worked as a floor NA Tuesday (09/08/15) and as not sure if anyone else applied the elbow splint. She stated Monday was the last time she provided services to Resident #56. On 09/11/15 at 10:15 AM, Resident #56 tolerated passive range of motion provided by NA #4, and allowed the elbow splint to be applied. Telephone interview on 09/11/15 at 10:36 AM with NA #5, who worked as a restorative aide at times, revealed she last completed restorative duties a week and a half ago. She stated that she applied the elbow splint but did not know anything about the need for passive range of motion. She again stated she only applied the elbow splint but did not provide range of motion.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING _____ B. WING _____	09/11/2015

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

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F 0318 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 14) Telephone interview on 09/11/15 at 1:00 PM with NA #6, who worked as a restorative aide at times, revealed she knew to provide passive range of motion and apply the palm guard and elbow splint, but stated Resident #56 refused the palm guard. NA #6 stated the last time she worked with Resident #56 was last Saturday (09/05/15). She further stated that when she was assigned as a floor nurse aide, she did not provide restorative services. On 09/11/15 at 1:52 PM, Restorative Nurse stated the referral from therapy that she received instructed staff to complete range of motion and apply the splint. She further stated that when the referral did not specify what splint to use, she assumed it was the palm guard which was previously being used. She provided a computerized Rehab Communication to Nursing form signed by a rehab aide which indicated restorative was to begin on 05/12/15 to include passive range of motion to the left shoulder, elbow, wrist and fingers and a splint. The form did not specify the type of splint to be used. She further stated when she had provided restorative services (documented on 08/21/15 and on 09/07/15) she did not know an elbow splint was being utilized on Resident #56 and did not apply it. Restorative nurse further stated she was not involved in the discharge instructions provided by therapy to the staff and just took the written information off the referral form when she developed the restorative plan of care. In addition, there was no documentation that range of motion or splint application had been provided on 09/08/15, 09/09/15, and 09/10/15.
F 0328 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Properly care for residents needing special services, including: injections, colostomy, ureostomy, ileostomy, tracheostomy care, tracheal suctioning, respiratory care, foot care, and prostheses** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, medical record reviews, resident, family, and staff interviews, the facility failed to monitor oxygen saturations and provide oxygen therapy for 1 of 3 residents reviewed for special needs (Residents #11). The findings included: The facilities policy and procedure as to check a resident's O2 saturation and/or vital signs read in part, check vital signs as facility protocol. The protocol was not clear as to when and/or how often a resident on oxygen therapy was to be checked and monitored. Resident #11 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set ((MDS) dated [DATE] indicated Resident #11 had short and long term memory impairment and severely impaired cognitive skills for daily decision making. Resident #11 was characterized as usually making self-understood and responded adequately to simple direct communication. Resident #11 required extensive assistance with activities of daily living (ADLs) including bed mobility, transfers, eating, personal hygiene, and dressing and was totally dependent on staff for bathing. Further review of the MDS revealed under section O for special treatments indicated Resident #11 required respiratory treatments which included the use of oxygen therapy while she was a resident. Review of a physician's orders [REDACTED].#11 to have oxygen at 2 Liters per minute (2L/min) via nasal cannula (NC) as needed for shortness of breath or if oxygen saturation (O2) was 90 % or less. Further review of the physician's orders [REDACTED]. Review of the electronic O2 saturation summary dated 06/04/15 through 09/11/15 revealed the following oxygen level readings: · 06/04/15 94 % with the administration of oxygen at 2L/min via NC · 06/07/15 95 % with the administration of oxygen at 2L/min via NC · 08/20/15 95 % with the administration of oxygen at 2L/min via NC · 08/25/15 95 % no oxygen in use (room air) Review of the Medication Administration Record [REDACTED]. Review of Resident #11's vital signs summary provided by the facility revealed the resident's oxygen saturations had not been checked since 08/25/15. Review of the physician's notes read in part the following: · Entry dated 07/10/15 the resident was diagnosed with [REDACTED]. · Entry dated 07/31/15 the resident was post status pneumonia with normal respiratory efforts but decreased breath sounds bilaterally with a plan to continue the oxygen due to [MEDICAL CONDITIONS]. Review of Resident #11's care plan dated 07/20/15 indicated ineffective breathing pattern related to [MEDICAL CONDITION] and interventions included to monitor the resident for signs and symptoms of insufficient breathing patterns, monitor vital signs as ordered, and continue with oxygen therapy. On 09/10/15 at 3:20 PM, Resident #11 was observed setting in her bed, arthritic hands, and minimal movement of her arms, the resident's oxygen concentrator was setting in the floor on the right side of the bed next to the wall with a bottle of water for humidified oxygen and the concentrator was set at 2 Liters per minute. The oxygen tubing was observed to be lying in the floor on the right side of the resident's bed and Resident #11 did not appear to be in any respiratory distress. On 09/10/15 at 3:30 PM, an interview was conducted with Resident #11, when asked about the oxygen therapy she stated, I took it off to rub my nose because my nose is dry and it itches, it fell in the floor, and I can ' t reach it, and I can't find my call bell. The resident was asked if she needed the oxygen all of the time she replied, I have to have it because I get really short of breath and can't breathe. On 09/10/15 @ 3:57 PM, observed Nurse #2 go into Resident #11's room to administer medication and the nurse did not place the oxygen therapy by nasal cannula (NC) into the resident's nose. Resident #11 was not observed to have asked Nurse #2 for the oxygen. On 09/10/15 at 4:00 PM, an interview was conducted with Nurse #2. She stated she was expected to ensure a resident's oxygen tubing was in place. Nurse #2 confirmed the oxygen tubing was not in the resident's nose and she was observed to pick up the tubing from the floor and place it into the resident's nose. Nurse #2 was observed not to have checked Resident #11's O2 saturation before administering the oxygen therapy. On 09/11/15 at 7:25 AM, Resident #11 was observed in her bed, with no oxygen in place, and the oxygen tubing was tucked behind the resident's head between the bed sheet and pillow. On 09/11/15 at 8:15 AM, Nurse #2 was observed to place the oxygen tubing into Resident #11's nose before she started feeding the resident her breakfast meal. Nurse #2 was observed as to not check the resident's O2 saturation before placing the oxygen tubing in the resident's nose. On 09/11/15 at 2:30 PM, an interview was conducted with Resident #11's family member. He was observed to pick up the resident's oxygen tubing out of the floor from behind the head of the resident's bed and placed it in the resident's nose. He stated there is no continuity of care and the staff are supposed to monitor her oxygen level and they can't seem to even do that. The family member further stated Resident #11's oxygen therapy was supposed to be continuous from 07/2015 when she was diagnosed with [REDACTED].#11's oxygen level was and they had informed him that it was good. The family member replied that he had not been told an actually number of the resident's O2 saturation. On 09/11/15 at 8:00 PM, the Director of Nursing (DON) was interviewed. She stated she would have expected the nurse's to have checked and recorded Resident #11's O2 saturations. The DON printed and provided the O2 saturation summary and acknowledged that it was all she was able to find.
F 0353 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have enough nurses to care for every resident in a way that maximizes the resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, family, staff, and resident interviews, the facility failed to provide sufficient nursing staff to meet the needs for 8 of 8 residents on 2 of 2 halls in the areas of staff not knowing the residents and/or what the needs of the residents were and services to meet the residents activities of daily living needs (Residents #92, #11, #59, #46, #53, #56, #5, and #25).

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F 0353 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 15) The findings included: This tag is cross referred to: 1) F 241 Based on observations, record review, staff and resident interviews, the facility failed to provide a bed pan upon request and failed to help obtain matching shoes after staff were informed of lost shoes for 2 of 4 residents (Residents #26 and #56). 2) F 242 Based on record review, resident, and staff interviews, the facility failed to assist a resident with showers for 1 of 3 residents who were reviewed for choices (Resident #46). 3) F 311 Based on observations, record reviews, staff, and resident interviews, the facility failed to assist with feeding 2 of 4 residents (Residents #5 and #25) sampled for requiring limited assistance with feeding and failed to assist with showering 1 of 2 residents (Resident #46) sampled who required limited assistance with showers. 4) F 312 Based on observations, record reviews, family, resident, and staff interviews, the facility failed to provide personal hygiene for dependent residents in need of showering, shaving, oral care, and finger nail care for 5 of 8 residents reviewed for activities of daily living (Residents #92, #11, #59, #53, and #48). 5) F 318 Based on observations, record review, resident, and staff interviews, the facility failed to provide an elbow splint and range of motion to 1 of 3 residents sampled for contractures with the restorative program established by the skilled therapy department (Resident #56). On 09/08/15 at 11:39 AM, Resident #56 who's quarterly Minimum Data Set ((MDS) dated [DATE] coded her as cognitively intact and requiring extensive assistance with most activities of daily living (ADLs) except for eating, stated she could not get the bed pan quick enough and that she had to wait up to an hour or more for staff assistance. An interview was conducted on 09/08/15 at 2:00 PM with Nurse Aide (NA) #7. She stated she was employed at another facility and was pulled from that facility within the corporation to work due to the facility being short staffed. She indicated she was supposed to keep the residents clean and dry and to assist the residents with eating. She further indicated there were days when there were only 2 NAs per hall and it was difficult to complete showers and/or provide residents with the assistance needed to meet their ADL needs, such as cutting nails, oral care, or shaving. An interview was conducted on 09/08/15 at 2:15 PM with NA #9. She stated she was an NA at another facility within the corporation and she was pulled to this facility due to the facility being short staffed. NA #9 indicated she and NA #7 worked together on the hall and they were not as familiar with the residents or their needs and that they had only been providing the minimal care such as assistance with eating, toileting, and keeping the residents clean and dry. She further stated they did not have the time to shave, shower, bathe, or provide oral care to the residents. A review of the employee list provided by the facility revealed a total of 6 full-time nurses and 13 full-time nurse aides for 3 shifts/7 days per week; 1st shift (7:00 AM to 3:00 PM), 2nd shift (3:00 PM to 11:00 PM), and 3rd shift (11:00 PM to 7:00 AM). NA #7 and NA #9 were not listed on the facility's employee list. On 09/10/15 at 8:20 AM, NA #10 stated she was leaving for the day that she had worked the night before and had also worked at least 12 hours the day before, she stated this is typical. NA #10 reported the staffing on 3rd shift was 2 NAs and 2 Nurses for the building. She further stated it was hard to get things done because on the main hall were the total care residents. She indicated it was hard to keep track of all of the residents and what their needs were when there were only 2 NAs on a hall and the NAs were always moving or being pulled to work on the hall that was short staffed. NA #10 indicated the resident showers were not given because there was not enough time. An interview was conducted on 09/10/15 at 12:30 PM with Resident #59's family member. The family member stated she had asked staff for assistance to take Resident #59 to the bathroom around 12:00 PM and that no one had come to the room to assist them. The family member further stated she was upset and that it usually took at least 30 minutes or longer for staff to assist the resident. An interview was conducted on 09/10/15 at 1:15 PM with NA #3. NA #3 stated the NAs worked short staffed most days. NA #3 stated with 2 NAs on the hall it was impossible to complete all care such as assisting residents to the toilet, shaving, oral care, showers, making and changing beds. NA #3 reported some residents had to wait long periods of time to be changed when wet or taken to the toilet due to the facility being short staffed. An interview was conducted on 09/10/15 at 1:25 PM with Nurse #1. She stated she was assisting on the hall today in the capacity of a Nurse Aide due to the hall being short staffed. She further stated the NAs could not keep the residents clean, dry, complete showers, and the ADLs were not getting done due to lack of staffing. Nurse #1 reported that the nurses have had to work as NAs at least 1 to 2 days a week in the past 3 months due to the facility being short staffed. An interview was conducted with Nurse #2 on 09/10/15 at 4:15 PM. She stated it was her expectation for a resident's oral care be provided at least once daily. Nurse #2 confirmed the resident's oral care had not been provided. Nurse #2 reported due to working short staffed the NAs had not had time to provide Resident #11's oral care today and the resident's basic needs were met such as keeping them clean and dry, and showering, shaving, oral care, and nail care was completed if there was extra staff on the hall. On 09/11/15 at 7:44 AM, Resident #56 was observed in bed with her uncovered tray in front of her. She stated she needed to urinate and had requested a bed pan but was told by the nurse aide that she had to pass the trays on the hall first. Resident #56 stated she did not think she could wait that long to use the bed pan as she really had to use the bedpan. After activating the call light again, NA #1 came into the room and confirmed Resident #56 had asked for a bed pan and NA #1 did tell her she could not place her on the bedpan until the trays were passed. At this time NA #2 entered the room to assist with repositioning. NA #2 and NA #1 stated they were trained in school that they could not assist a resident with toileting or placing them on a bed pan while the trays were being passed because it was a breach of infection control. At this time, NAs #1 and #2 placed Resident #56 on the bed pan. At 7:54 AM, NA #2 stated Resident #56 was continent when placed on the bedpan. An interview was conducted on 09/11/15 at 8:30 AM with NA #2. NA #2 stated he was mad and upset that the 3rd shift NA had not made rounds and cleaned/dried the residents before the breakfast trays had come to the hall. NA #2 reported there was only 1 NA after 3:00 AM for the hall and that it was impossible for the residents to be changed, cleaned, dried, and be gotten up before 1st shift come in and/or the breakfast trays come to the hall. NA #2 further stated the NAs do the best they can and that it was impossible to complete the resident's care such as showers, oral care, and shaving due to the facility being short staffed. An interview was conducted on 09/11/15 at 9:45 AM with Resident #46. The resident stated he was capable of shaving himself with his electric razor and completing most all of his hygiene except for his showers. He indicated he needed assistance with the showers and that he had not had a shower since 08/24/15 due to the facility being short staffed. He also indicated the NAs had assisted him with a bed bath and he had asked for a shower and the staff had told him they would give him a shower as soon as they had time. Resident #46 stated the bed linens were supposed to be changed on shower days and that his bed linens were soiled and had not been changed since 08/24/15. Resident #46 stated he thought staff was just too busy to worry about changing bed linens or assisting with showers. A review of the employee list provided by the facility revealed a total of 6 full-time nurses and 13 full-time nurse aides for 3 shifts/7 days per week; 1st shift (7:00 AM to 3:00 PM), 2nd shift (3:00 PM to 11:00 PM), and 3rd shift (11:00 PM to 7:00 AM). A follow-up interview was conducted on 09/11/15 at 10:15 AM with Nurse #1. She stated she had been assigned to assist on the halls in the capacity of a Nurse Aide due to the halls being short staffed and that she was assigned today as a hall nurse. She further stated the NAs could not keep the residents clean, dry, complete showers, and the ADLs were not getting done due to lack of staffing. Nurse #1 reported that the nurses have had to work as NAs at least 1 to 2 days a week in the past 3 months due to the facility being short staffed. A follow-up interview was conducted on 09/11/15 at 10:30 AM with Nurse #2. She stated some residents had to wait long periods of time to be changed when wet and there had been times when residents would not get their showers on their scheduled days due to the facility being short staffed. Nurse #2 further stated she expected the bed linens to be changed on the residents shower days. Nurse #2 confirmed the tan colored stains on Resident #46's bed linens and stated she would have the linens changed immediately. An interview was conducted on 09/11/15 at 1:30 PM with NA #1. She stated the NAs worked short staffed most days and they no longer had a shower team. She further stated it was almost impossible to complete all care such as showers, nail care, shaving, oral care, and making and changing of bed linens. She indicated as short staffed as they were they focused on

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F 0353 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 16) toileting, changing, and feeding of the residents and the other care needs were completed on days if there were any extra staff working. An interview was conducted on 09/11/15 at 1:45 PM with NA #4. She stated she worked as a nurse aide on whichever hall was short staffed for that day. She further stated the 2 halls worked short staffed most days and that resident care needs such as showers, nail care, oral care and shaving were not provided on a scheduled weekly basis. She indicated when she worked as a float NA she would be assigned to give resident showers but for the last 2 to 3 months she had worked as a regular staff and not as a float NA. A review of staffing assignments for 08/31/15 to 09/11/15 revealed 20 out of 42 days NA #4 was pulled to work the floor to give each hall a minimum of 2 to 3 NAs. On 09/11/15 at 2:30 PM an interview was conducted with Resident #11's family member. The family member observed the resident's oxygen tubing lying in the floor and he was observed to pick up the oxygen tubing and placed it into the resident's nose. The family member stated the facility was short staffed and was unable to keep staff employed. The family member further stated he seldom missed a day visiting the resident and the staff were not providing the care to the residents as expected. The family member indicated that Resident #11's teeth were not brushed daily, her clothes were not changed every day unless he would asked them to change her, and that the resident was not being provided with showers. The family member further indicated there was no continuity of care and he expected the resident's face to be washed every morning, her clothes to be changed daily or more frequently if soiled, her teeth brushed at least daily, and a shower with her hair washed 2 times a week. The family member reported he had talked with the Director of Nursing (DON) several times in regards to his expectations and the care would get better for a little while and then the resident's care would start to decline again. An interview was conducted with Nurse #1 on 09/11/15 at 3:00 PM. She stated the NAs could not keep the residents clean, dry, complete showers, and the ADLs were not getting done due to lack of staffing. An interview was conducted with NA #8 on 09/11/15 at 3:17 PM. NA #8 stated that he had no time to brush any resident's teeth or provide anyone mouth care as he was on the hall by himself and was able to only keep up with changing the residents. An interview was conducted with Nurse #2 on 09/11/15 at 3:45 PM. She stated nail care and shaving was provided by the NAs on shower days and that oral care was to be provided on a daily basis. She revealed showers, nail care, shaving, or oral care was rarely done for residents and some residents had to wait long periods of time to be changed when wet due to the facility being short staffed. Nurse #1 indicated lunch trays were passed out late on many days due to lack of staffing on the halls or the residents which required assistance with eating would also have to wait long periods of time. An interview was conducted with the Director of Nursing (DON) on 09/11/15 at 8:00 PM. She stated it was her expectation that all care should be provided to the resident and if certain care areas were missed they should be reported for the next shift to do. The DON stated she was aware of the staffing shortage and the administrative staff was working to hire additional employees. The DON further stated she did not know what needs were not being met for the residents due to staffing. The DON confirmed there had been instances when staff from other facilities within the corporation worked to meet the resident's needs.
F 0356 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	**Post nurse staffing information/data on a daily basis.** Based on observations, record review and staff interviews the facility failed to post the nurse staffing data on a daily basis at the beginning of each shift, failed to post the data with the correct dates and failed to post the resident census in a clear and readable format for 4 of 4 days of the annual recertification survey. The findings included: During an observation on 09/08/15 at 2:50 PM the daily posted staffing was observed in a receptionist area next to the front lobby with the facility name and current date but the census which was 49 was documented as 49/4. The posted staffing also included the total numbers of nursing staff data for first, second and third shifts for a 24 hour period. During an observation on 09/09/15 at 8:35 AM the daily posted staffing was dated 09/10/15. The resident census was posted as 50/5 and included the total numbers of nursing staff data for first, second and third shifts for a 24 hour period. During an observation on 09/10/15 at 9:30 AM the daily posted staffing was dated 09/09/15. The resident census was posted as 50/5 and included the total numbers of nursing staff data for first, second and third shifts for a 24 hour period. During an observation on 09/11/15 at 7:54 AM the daily posted staffing was dated 09/10/15. The resident census was posted as 50/5 and included the total numbers of nursing staff data for first, second and third shifts for a 24 hour period. During an interview on 09/11/15 at 5:05 PM with the Director of Nursing she stated a receptionist in the facility had been assigned to post the daily staffing information but had not been trained on how to document the information. She explained there was no system in place to document the information on second or third shifts and that was the reason the information was only posted once daily. She confirmed the census numbers were inaccurate and the information needed to be posted in a timely manner with the correct dated.
F 0365 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide food in a way that meets a resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, resident interview and staff interview, the facility failed to provide finger foods to 1 of 1 resident sampled with orders for finger foods. (Resident #25). The finding included: Resident #25 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The admission Minimum (MDS) data set [DATE] coded him as being cognitively intact and requiring extensive assistance with eating. Resident #25 began occupational therapy (OT) on 05/11/15 with a goal to improve his self feeding abilities. On 05/20/15 a communication slip was sent to the kitchen stating Finger foods only please which was sent by OT. On 09/10/15 at 11:45 AM observations were made of the tray line in the kitchen. On the tray line were chicken and pastry, green peas and mushrooms, pureed chicken and pastry, pureed peas and mushrooms, mashed potatoes, green beans, stew beef, and rolls. On 09/10/15 at 12:34 PM, Resident #25 was served chicken and pastry in a bowl. At 12:34 Resident #42 was observed feeding Resident #25 the chicken and pastry as Nurse Aide (NA) #4 watched from nearby. At 12:34 PM, NA #4 asked Resident #42 if he wanted her to help Resident #25 to which Resident #42 replied no he could do it as he did it all the time. Resident #25 stated during interview on 09/10/15 at 12:56 PM, that the facility was supposed to send him finger foods, but they did not always have finger foods to send. Review of the meal spread sheets revealed residents with finger foods were to be served chicken bites with noodles. On 09/11/15 at 11:16 the Dietary Manager (DM) was interviewed. He stated finger foods were made daily but the kitchen tried to give what's on the menu if it was not too messy of an item to eat. After reviewing the spread sheets, DM stated Resident #25 should have received chicken bites with noodles. At 11:22 AM, when asked about having no finger foods on the tray line on 09/10/15, the cook, who prepared the food on 09/10/15, joined the conversation. The cook and the DM, both present when the surveyor tested the food temperatures on 09/10/15, confirmed there were no chicken and noodles prepared on 09/10/15. The cook stated she just over looked cooking them and the DM stated he overlooked the missing finger foods also. Review of the tray card for Resident #25 confirmed the card stated he was on a regular finger food diet. Interview with OT on 09/11/15 at 9:24 AM revealed Resident #25's ability to feed himself fluctuated. Therapy had tried weighted utensils, weighted cups, divided plate, etc. He preferred a regular cup and regular utensils. OT further stated that he should get finger foods when available. The Administrator stated during interview on 09/11/15 at 4:41 PM she expected the dietary staff to make the finger foods per the spread sheets daily.
F 0371 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Store, cook, and serve food in a safe and clean way** Based on observations and staff interview, the facility failed to discard outdated bread and keep scoops out of food stored in bins.

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	345219	A. BUILDING _____ B. WING _____	09/11/2015

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0371 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 17) The findings included: During initial tour of the kitchen on 09/08/15 at 10:06 AM the following was noted: *There were 6 bags of hot dog buns with past use by dates. Two bags had a use by date of 08/20/15. One of these bags contained buns covered in green powdery matter. Four bags had a use by date of 08/27/15. *The scoop was stored directly in the ice machine and not in the scoop holder. *The scoop was stored directly in the rice located in a large bin and not in the scoop holder. On 09/10/15 at 10:38 AM an Interview was conducted with the Dietary Manager (DM). DM stated that bread was delivered once a week. The delivery person rotated the bread, placing the older bread on top and the new bread below the older bread. In addition the DM stated he also checked for expiration dates daily. DM stated the facility received a delivery of bread on Monday 09/07/15 and he just missed seeing the outdated buns. DM further stated during interview on 09/10/15 at 10:38 AM that the scoops in the ice machine should be place in the holder next to the ice machine and the scoops for the food in the large bins should be stored in the holders located inside each of the bins. At this time a second check of the bins revealed the scoop was placed directly in the powdered thickener located in the large bin and not in the holder. On 09/11/15 at 4:41 PM the Administrator stated that a regional nurse made rounds in the kitchen on 09/04/15 and did not identify the expired bread.
F 0456 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep all essential equipment working safely.** Based on observations and staff interviews, the facility failed to provide maintenance to 1 of 1 kitchen freezer to prevent the accumulation of ice inside the freezer and over food items. The findings included: On 09/08/15 at 10:06 AM the freezer was observed. The cooling unit was located close to the ceiling with a pipe extending from the side of the unit to the ceiling. Under the cooling unit were shelves of food. The pipe leading to the ceiling was covered in icicles which extended down onto a box containing whipped topping, a box of pancakes and a container of ice cream. The ice remained around the pipe in the freezer during observation on 09/10/15 at 10:48 AM. This did not affect the temperature of the freezer. The Dietary Manager (DM) was interviewed at this time and stated he had told maintenance before about he leak in the freezer and reminded him again about it on Tuesday (09/08/15). Follow interview with DM on 09/11/15 at 11:13 AM revealed the freezer was fixed yesterday. DM stated he had noticed the freezer's ice build up back in November 2014 and told the previous maintenance man about the leak. DM stated he left employment with the facility in November and returned to the facility May 1st, 2015. He stated the freezer was still leaking with ice built up and he put a work order in for repair but it was never repaired. DM stated he again mentioned it to the maintenance man a few weeks ago and put in another work order. On 09/11/15 at 11:27 AM, an interview was conducted with the maintenance man. He stated that he had been employed at the facility 5 to 6 months and did not recall any mention or work order about the freezer leaking, until DM told him yesterday. He then went out and purchased caulking and applied it to the outside where the pipe leads from the ceiling out to the roof with plans to apply more caulking to the inside ceiling of the freezer soon. Review of work orders for November 2014, May 2015 and August 2015 revealed no work order for any kitchen problems. On 09/11/15 at 4:41 PM the Administrator stated that when a work order came in, she received a copy of it and then as the work was completed, she matched up the copy with the work order the maintenance man wrote his resolution on. In addition, a regional nurse made rounds in the kitchen on 09/04/15 and did not identify the freezer problem.
F 0514 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews the facility failed to document severity of pain or responses to pain medication for 1 of 3 residents sampled for pressure ulcers (Resident #53). The findings included: Resident #53 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the most recent annual Minimum Data Set ((MDS) dated [DATE] indicated Resident #53 was moderately impaired in cognition for daily decision making. The MDS indicated Resident #53 required extensive assistance with activities of daily living and was at risk for development of pressure ulcers. A review of physician's orders [REDACTED]. A review of a Medication Administration Record [REDACTED]. A review of a MAR indicated [REDACTED]. A review of physician's orders [REDACTED]. A review of a MAR indicated [REDACTED]. During an interview on 09/11/15 at 10:32 AM with the treatment nurse she explained the nurse who was assigned to the resident also provided treatments and gave medications to residents. She stated she had recently been assigned as a nurse on the hall in addition to her treatment duties because of staff vacancies in the facility. She verified documentation in the resident's medical records was poor because they were so busy and documentation was often left undone to provide care to residents. She explained staff were supposed to document the results or effectiveness of pain medication on the back of the MAR but staff had not documented it and she did not see the severity of Resident #53's pain documented. During an interview on 09/11/15 at 5:40 PM the DON stated it was her expectation for nurses to document the severity level of pain when resident's complained of pain. She also stated she expected nursing staff to document the effectiveness of pain medication given to the resident on the back of the MAR indicated [REDACTED]
F 0520 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.** Based on observations, record reviews, staff, and resident interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place September 2014. This was for two recited deficiencies which were originally cited in August 2014 on a recertification survey and again on the current recertification and complaint survey. The deficiencies were in the areas of choices and reviewing and revising comprehensive care plans. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referred to: 1a. F 242: Choices: Based on record review, resident, and staff interviews, the facility failed to assist a resident with showers for 1 of 3 residents who were reviewed for choices (Resident #46). The facility was originally cited for F 242 for failing to provide residents with the number of showers they preferred for 1 of 3 residents during the August 28, 2014 recertification survey. On the current recertification and complaint survey the facility was again cited for failing to provide a resident showers preferred each week. b. F 280: Update Comprehensive Plan: Based on observations, record review, and staff interviews, the facility failed to revise a care plan for a resident with contractures for 1 of 3 residents reviewed for care plans (Resident #56). The facility was originally cited for F 280 for failing to review and revise care plan interventions for 2 of 5 residents during the August 28, 2014 recertification survey. On the current recertification and complaint survey the facility was again cited for failing to revise comprehensive care plans.

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

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F 0520 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 18) An interview was conducted with the Administrator and the Director of Nursing (DON) on 09/11/15 at 8:00 PM. The Administrator stated she began working at the facility as the interim administrator in August 2015. The administrator stated she had not attended a Quality Assurance meeting but was planning to attend the meeting scheduled for September 2015. The DON stated she began working at the facility in July 2014. The DON stated they had been unable to get to the bottom or the root cause of the problems for numerous other concerns. The DON further stated these were ongoing processes and there was still a lot of work to be done.