

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/21/2024
NAME OF PROVIDER OR SUPPLIER Magnolia Gardens Center for Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1028 Blair Street Thomasville, NC 27360	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46095</p> <p>Based on record review, observations, resident, and staff interviews the facility failed to provide care in a manner to maintain the resident ' s dignity by not answering call bells for residents that need extensive assistance with activities of daily living (ADLs). This was evident for 3 of 6 residents (Resident #10, Resident #3, and Resident #4) reviewed for dignity.</p> <p>Findings include:</p> <p>1. Resident #10 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD), rheumatoid arthritis, diabetes mellitus, and osteoarthritis of right knee.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #10 ' s cognition was intact. She required moderate assistance with toileting, shower/baths, and personal hygiene. She required maximum assistance with dressing and was dependent on staff for transfers. She was always incontinent of bowel and bladder.</p> <p>An interview on 05/08/24 at 10:21 AM with Resident #10 was conducted. She stated she had waited up to 2 hours for her call light to be answered, which resulted in her sitting in urine and bowel movement. She indicated she did not want to sit in a soiled brief. She did not recall the dates of the occurrences. She then stated she can time how long the call light had been on according to what she ' s watching on TV at the time.</p> <p>Resident Council minutes reviewed for 09/07/23, 10/03/23, 11/02/23, and 01/04/24 revealed concerns related to Nursing Assistants (NAs) not providing activity of daily living (ADL) care. On 12/07/23, 02/08/24, 03/07/24, and 04/24/24 concerns related to Nursing Assistants (NAs) call light response time were voiced.</p> <p>An interview was conducted on 05/09/24 at 1:08 PM with the Assistant Director of Nursing (ADON). The ADON stated she did pull NA #1 to assist with transportation during the morning of 05/09/24 and she made the nurses and other NAs know she would be off the hall. She stated the other NAs on the hall would assist in covering the section until the NA returned.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted on 05/09/24 at 1:10 PM with the Director of Nursing (DON). The DON stated she was unaware of the wait times and staff not answering call bells. She also stated her expectations is for the call lights to be answered in a timely manner by all staff.</p> <p>2. Resident #3 was admitted to the facility on [DATE] with diagnosis that included Parkinson ' s Disease, diabetes mellitus, and Dementia.</p> <p>Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #3 cognition was moderately impaired. She required set-up/clean-up assistance with toileting, minimal assistance with eating, oral hygiene, and personal hygiene. She also required moderate assistance with shower/baths and dressing. She had limited range of motion (ROM) to one side of her upper extremities.</p> <p>A continuous observation and interview on 05/09/24 from 9:44 AM through 10:13 AM revealed call lights were activated. Nursing Assistant (NA) #2 was noted sitting at the nurses ' station in front of the computer. NA #2 was asked if she was aware the call lights were activated and she stated, They ' re not my residents and then stated, I thought that nursing assistant had returned to the hall. She indicated she normally answered any call lights that were activated, and she should not have assumed NA # 1 was going to do so.</p> <p>An interview was conducted on 05/09/24 at 11:40 AM with Nursing Assistant (NA) #1. She verified she was the direct care Nursing Assistant (NA) for Resident #3 ' s room. She stated she answered the call bells as timely as she could however this morning she had been pulled to assist with transportation and was not on the floor for a period of time. She stated the nurses and other NAs knew she would be off the hall for transportation. She stated she did not tell other staff she was leaving her assignment, but the ADON was on the floor, and she did.</p> <p>Resident Council minutes reviewed for 09/07/23, 10/03/23, 11/02/23, and 01/04/24 revealed concerns related to Nursing Assistants (NAs) not providing activity of daily living (ADL) care. On 12/07/23, 02/08/24, 03/07/24, and 04/24/24 concerns related to Nursing Assistants (NAs) call light response time were voiced.</p> <p>An interview was conducted on 05/09/24 at 1:08 PM with the Assistant Director of Nursing (ADON). The ADON stated she did pull NA #1 to assist with transportation during the morning of 05/09/24 and she made the nurses and other NAs know she would be off the hall. She stated the other NAs on the hall would assist in covering the section until the NA returned.</p> <p>An interview was conducted on 05/09/24 at 1:10 PM with the Director of Nursing (DON). The DON stated she was unaware of the wait times and staff not answering call bells. She also stated her expectations is for the call lights to be answered in a timely manner by all staff.</p> <p>An interview was conducted on 05/09/24 at 1:55 PM with Resident #3. She revealed that when she activated her call light to request assistance on 05/09/24 at about 09:45 AM, it took staff 30 minutes to come to her room. She did not recall why she activated the call light at that time. She indicated she often had to wait up to an hour for help after she activated the call light. She also stated she got frustrated and helpless when staff do not respond timely. She further stated it doesn ' t feel good to be wet that long. She indicated when the State was in the building, the staff answered the call bell a lot faster than if they were not.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Resident #4 was admitted to the facility on [DATE] with diagnoses that included heart failure, chronic obstructive pulmonary disease (COPD), difficulty walking, history of falls, and unsteadiness on feet.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #4 ' s cognition was intact. She required set-up/clean-up assistance with toileting, personal hygiene, and dressing. She required minimal assistance with showing/bathing and was occasionally incontinent of bladder.</p> <p>A continuous observation and interview on 05/09/24 from 9:44 AM through 10:13 AM revealed call lights for rooms [ROOM NUMBERS] were activated. Nursing Assistant (NA) #2 was noted sitting at the nurses ' station in front of the computer. NA #2 was asked if she was aware the call lights were activated and she stated, there not my residents and then also stated, I thought that NA had returned to the hall. She indicated she normally answered any call lights that were activated, and she should not have assumed NA # 1 was going to do so.</p> <p>An interview was conducted on 05/09/24 at 11:40 AM with Nursing Assistant (NA) #1. She verified she was the direct care Nursing Assistant (NA) for rooms [ROOM NUMBERS]. She stated she answered the call bells as timely as she could however this morning she had been pulled to assist with transportation and was not on the floor for a period of time. She stated the nurses and other NAs knew she would be off the hall for transportation. She stated she did not tell other staff she was leaving her assignment, but the ADON was on the floor, and she did.</p> <p>Resident Council minutes reviewed for 09/07/23, 10/03/23, 11/02/23, and 01/04/24 revealed concerns related to Nursing Assistants (NAs) not providing activity of daily living (ADL) care. On 12/07/23, 02/08/24, 03/07/24, and 04/24/24 concerns related to Nursing Assistants (NAs) call light response time were voiced.</p> <p>An interview was conducted on 05/09/24 at 1:08 PM with the Assistant Director of Nursing (ADON). The ADON stated she did pull NA #1 to assist with transportation during the morning of 05/09/24 and she made the nurses and other NAs know she would be off the hall. She stated the other NAs on the hall would assist in covering the section until the NA returned.</p> <p>An interview was conducted on 05/09/24 at 1:10 PM with the Director of Nursing (DON). The DON stated she was unaware of the wait times and staff not answering call bells. She also stated her expectations is for the call lights to be answered in a timely manner by all staff.</p> <p>An interview was conducted on 05/09/24 at 1:45 PM with Resident #4. She revealed that when she activated her call light to request assistance on 05/09/24 at about 09:45 AM, it took staff 30 minutes to come to her room. She indicated she needed ice at that time, but it should not matter what the need was. She then stated it made her mad and upset when staff are heard talking about personal things, but they wouldn ' t answer the call light.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46095</p> <p>Based on observation, record review, resident interviews, and staff interviews, the facility failed to place a resident's call light (Resident #5 and #7) within reach to allow for the residents to request staff assistance this was for 2 of 3 residents reviewed for accommodation of needs.</p> <p>The findings included:</p> <p>1. Resident #7 was admitted to the facility on [DATE] with diagnosis that included epilepsy and epileptic syndromes, history of falls, traumatic brain injury and traumatic subdural hemorrhage with loss of consciousness.</p> <p>The annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #7 ' s cognition was severely impaired. He had no behavior and no rejection of care. He required minimum assistance of 1 for toileting hygiene and personal hygiene and required maximum assistance with shower/baths. He was occasionally incontinent of bladder and always continent of bowel. He had no functional limitation with range of motion of her extremities.</p> <p>Resident #5's active care plan, last revised on 04/23/24, indicated he had an activities of daily living (ADL) self-care performance deficit related to a history of traumatic subdural hemorrhage with loss of consciousness from a fall downstairs and cognitive impairment. The interventions included for staff to encourage him to use his bell to call for assistance. Another focus read Resident #5 had an actual fall and was at risk for additional falls related to confusion and history of a fall with serious injury prior to admit to facility. The interventions included for staff to be sure his call light was within reach and encourage the resident to use it for assistance as needed. The resident needs a prompt response to all requests for assistance.</p> <p>An observation was conducted on 05/08/24 at 9:55 AM of Resident #7 lying in bed resting with eyes closed. His call bell was tied onto the bottom of the grab rail on the left side of bed out of the residents ' reach. Resident #7 declined to be interviewed.</p> <p>An interview was conducted with Nursing Assistant (NA) #1 on 05/09/24 at 11:40 AM. She verified she was the direct care NA for Resident #7 ' s room. She indicated she checked call bell placement prior to leaving the rooms. NA #1 verified Resident #7 does utilize his call bell for assistance at times. She indicated she did not check his call bell placement upon leaving his room today.</p> <p>An interview was conducted on 05/09/24 at 10:52 AM with Nurse #1. She verified that Resident #7 ' s call bell was tied on the bottom of the grab rail where the resident could not reach it. She indicated he gets up unassisted and ambulated but had used the call bell in the past. She stated Resident #7 does require assistance with his activities of daily living (ADLs).</p> <p>An interview was conducted on 05/09/24 at 1:10 PM with the Director of Nursing (DON). She stated the call bell device should always be within the resident ' s reach.</p> <p>2. Resident #5 was admitted to the facility on [DATE] with diagnosis that included chronic osteomyelitis (inflammation of bone or bone marrow) of right thigh and difficulty walking.</p> <p>(continued on next page)</p>

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #5 's cognition was intact. She had no behavior and no rejection of care. She required moderate assistance of 1 for toileting hygiene and minimal assistance with shower/baths. She was always continent of bowel and bladder. She had no functional limitation with range of motion of her extremities.</p> <p>Resident #5's active care plan, last revised on 04/23/24, indicated she had an activities of daily living (ADL) self-care performance deficit related to pain in her right hip. The interventions included for staff to encourage the resident to use bell to call for assistance. Another focus read Resident #5 had an actual fall and was at risk for additional falls related to generalized muscle weakness and poor safety awareness. The interventions included for staff to be sure her call light was within reach and encourage the resident to use it.</p> <p>An observation and interview were conducted on 05/08/24 at 10:15 AM. Resident #5 's call bell was located on the floor behind a box at the head of bed. Resident indicated she could not locate her call bell. She stated she did not know how the call bell got up against the wall under the box, it had been there a while. She also stated she would use her call bell if she needed to.</p> <p>An interview was conducted on 05/08/24 at 10:18 AM with NA #3. She verified she was the direct care NA for Resident #5 and that her call bell was on floor behind a box at head of bed. She stated Resident #5 does not use her call bell, but she does require assistance with her activities of daily living (ADLs). She stated she checks for call bell placement prior to leaving a room but she did not recall if she checked Resident #5 's call bell the last time she was in the room.</p> <p>An observation was conducted on 05/09/24 at 10:10 AM. Resident #5 's call bell was located on the floor behind a box at head of bed. Resident stated the call bell was under a box and she could not currently reach it. She stated she did not know how the call bell got under the box; it had been there a while. She indicated she did not use the call bell often, but she would if it was within reach, and she needed to do so.</p> <p>An interview was conducted on 05/09/24 at 10:52 AM with Nurse #1. She verified that the Resident #5 's call bell was on floor behind a box at head of bed. She stated Resident #5 did not normally use her call bell, but she does require assistance with her activities of daily living (ADLs).</p> <p>An interview was conducted on 05/09/24 at 1:10 PM with the Director of Nursing (DON). She stated the call bell device should always be within the resident 's reach.</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>46095</p> <p>Based on record review, resident, and staff interviews, the facility failed to communicate the facility's efforts to address group concerns verbalized during Resident Council meetings and to resolve repeat concerns for 8 of 9 consecutive months (September 2023, October 2023, November 2023, December 2023, January 2024, February 2024, March 2024, and April 2024).</p> <p>Findings included:</p> <p>a. Resident Council minutes dated 09/07/23 indicated residents had voiced concerns related to Nursing Assistants (NAs) not providing activity of daily living (ADL) care (not following the bath schedule) and food being cold when served. There was no evidence of the facility ' s response to the concerns voiced during the previous meeting had been reviewed or discussed.</p> <p>b. Resident Council minutes dated 10/03/23 indicated residents had voiced concerns related to Nursing Assistants (NAs) not providing activity of daily living (ADL) care (NAs leaving residents soiled for extended period) and food being cold when served. There was no evidence of the facility ' s response to the concerns voiced during the previous meeting had been reviewed or discussed.</p> <p>c. Resident Council minutes dated 11/02/23 indicated residents had voiced concerns related to Nursing Assistants (NAs) not providing activity of daily living (ADL) care and food not being on time. There was no evidence of the facility ' s response to the concerns voiced during the previous meeting had been reviewed or discussed.</p> <p>d. Resident Council minutes dated 12/07/23 indicated residents had voiced concerns related to Nursing Assistants (NAs) call light response time and food being cold when served. There was no evidence of the facility ' s response to the concerns voiced during the previous meeting had been reviewed or discussed.</p> <p>e. Resident Council minutes dated 01/04/24 indicated residents had voiced concerns related to Nursing Assistants (NAs) not providing activity of daily living (ADL) care (not following the bath schedule) and food being cold when served. There was no evidence of the facility ' s response to the concerns voiced during the previous meeting had been reviewed or discussed.</p> <p>d. Resident Council minutes dated 02/08/24 indicated residents had voiced concerns related to Nursing Assistants (NAs) call light response time slow and food not coming out on time. There was no evidence of the facility ' s response to the concerns voiced during the previous meeting had been reviewed or discussed.</p> <p>e. Resident Council minutes dated 03/07/24 indicated residents had voiced concerns related to Nursing Assistants (NAs) call light response time slow and food being cold when served. There was no evidence of the facility ' s response to the concerns voiced during the previous meeting had been reviewed or discussed.</p> <p>(continued on next page)</p>

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>f. Resident Council minutes dated 04/24/24 indicated residents had voiced concerns related to Nursing Assistants (NAs) call light response time slow. There was no evidence of the facility ' s response to the concerns voiced during the previous meeting had been reviewed or discussed.</p> <p>The facility ' s concern log revealed no documented concerns from the Resident Council from September 2023 through April 2024.</p> <p>An interview was conducted on 05/08/24 at 12:45 PM with the Administrator. He indicated the concerns that were reported in resident council meetings would be written up by the Activity Director and given to the department head responsible so an investigation could be conducted. He was unaware the resident concerns were not addressed from September 2023 through April 2024.</p> <p>An interview was conducted on 05/09/24 at 12:45 PM with Resident # 11, Resident Council President, and Resident #12, Resident Council Co-President, was conducted. Resident # 11 stated they did not receive feedback from staff when group concerns were voiced. Resident # 11 further voiced they have complained multiple times regarding receiving activity of daily living (ADL) care and call bell response time being slow, however, nothing gets resolved. He then stated the Nursing Assistants (NAs) stand around at the nurses ' station and gossip and talk about personal things until 7:45-8:00 AM when they should be starting work at 7:00 AM. He indicated he did not know if the old Activity Director was giving the concerns to the Director of Nursing (DON) or the Administrator. Resident # 12 agreed with Resident # 11 ' s comments.</p> <p>Multiple phone calls to contact the Previous Activities Director were unsuccessful. The Previous Activities Director was employed from 08/02/23 through 04/09/24.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46095</p> <p>Based on record review and staff interviews, the facility's administration failed to investigate and complete a root cause analysis for a fall for 1 of 4 residents reviewed for accidents. (Resident #8). The deficient practice led to the inability to implement effective interventions to prevent a reoccurrence.</p> <p>The findings included:</p> <p>Resident # 8 was admitted to the facility on [DATE] with diagnosis that included disorder of the brain, repeated falls, and paranoid schizophrenia.</p> <p>Resident #8 ' s significant change Minimum Dat Set (MDS) assessment dated [DATE] indicated her cognition was severely impaired. She had one fall with major injury since admission or reentry. She required moderate assistance for bed mobility and minimal assistance for transfers.</p> <p>Resident #8 ' s care plan, last revised 04/23/24, indicated she was at risk for falls related to confusion, deconditioning, impaired balance during transitions; poor safety awareness, and she does not call for assistance. The interventions included for staff to anticipate and meet the resident's needs, be sure call light is within reach and encourage the resident to use it for assistance as needed. The resident needed a prompt response to all requests for assistance and to ensure that the resident is wearing appropriate footwear when ambulating.</p> <p>An incident report, dated 04/25/24, revealed a fall with no injury. Resident #8 was noted to be sitting upright in hall. Resident #8 stated she was trying to go backwards in her wheelchair and fell out of it. The report also revealed she was alert and oriented to person, place, time, and situation with predisposing factor being gait imbalance.</p> <p>The nursing notes reviewed from 04/25/24 through 05/08/24 there was no at risk meeting related to fall that occurred on 04/25/24.</p> <p>An interview was conducted on 05/08/24 at 1:32 PM with the Director of Nursing (DON). She stated falls are discussed every morning in the meeting and then documented in the nurses ' notes. She indicated she did not have an actual at risk meeting. She also indicated she was responsible for completing a root cause analysis for falls. She further stated if there were no notes documented in the nursing notes regarding a fall then there were not any. She was unable to provide documentation of root cause analysis for Resident #8 ' s fall on 04/25/24.</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>46095</p> <p>Based on observations, record review, and staff interview the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification and complaint investigation surveys completed on 09/01/22 and 07/20/23. This was for 2 deficiencies that were cited in the areas of Resident Rights/Exercise of Rights and Reasonable Accommodation of Needs/Preferences. Resident Rights/Exercise of Rights was cited on the recertification and complaint survey on 09/01/22 and recited on the current complaint survey of 05/09/24. Reasonable Accommodation of Needs/Preferences was cited on 07/20/23 and recited on the current complaint survey of 05/09/24. The continued failure of the facility during three federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program (QA).</p> <p>The findings included:</p> <p>This citation is cross referred to:</p> <p>1. F550-Based on record review, observations, resident, and staff interviews the facility failed to provide care in a manner to maintain the resident's dignity by not answering call bells for residents that need extensive assistance with activities of daily living (ADLs). This was evident for 3 of 6 residents (Resident #10, Resident #3, and Resident #4) reviewed for dignity.</p> <p>During the facility's recertification and complaint survey of 9/1/22, the facility failed to promote dignity by not providing privacy cover over a urinary catheter drainage bag for one resident. This occurred for 1 of 6 residents reviewed for dignity.</p> <p>2. F558-Based on observation, record review, resident interviews, and staff interviews, the facility failed to place a resident's call light (Resident #5 and #7) within reach to allow for the residents to request staff assistance this was for 2 of 3 residents reviewed for accommodation of needs.</p> <p>During the facility's recertification and complaint survey of 07/20/23, the facility failed to provide a dependent resident with a wheelchair to accommodate her size and inability to sit up. The resident was unable to get out of bed unless the staff borrowed a wheelchair from another resident with the same accommodation needs for 1 of 2 residents reviewed for accommodation of needs.</p> <p>A phone interview was conducted on 05/21/24 at 3:23 PM with the Administrator. He stated the citations repeated, but the same issues did not repeat. He indicated he felt the current interventions in place are effective for the issues being cited in previous surveys.</p>		