

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL082022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/13/2022
NAME OF PROVIDER OR SUPPLIER THE MAGNOLIA		STREET ADDRESS, CITY, STATE, ZIP CODE 213 FOREST TRAIL CLINTON, NC 28328		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Sampson County Department of Social Services conducted an annual survey and a complaint investigation on January 11, 2022 - January 13, 2022.	D 000	Response to cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law.	
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure personal care assistance was provided for 7 of 10 sampled residents (#2, #3, #4, #7, #8, #9, #10) on the Special Care Unit (SCU) including being dressed appropriately (#4, #7) which included a resident's pants on backwards and a saturated to sagging brief (#7) and a resident's pants and a brief down around the resident's knees (#4), hair being neatly groomed (#2, #3, #4, #8, #9, #10), facial hair being neatly groomed (#7) and oral hygiene being completed (#2). The findings are: 1. Review of Resident #2's current FL-2 dated 01/06/22 revealed: -Diagnoses included dementia, hypernatremia, acute kidney injury, dehydration, and urinary tract	D 269	The Magnolia shall ensure that staff provides personal care to residents according to their care plans, and attend to any other personal care needs that they may be unable to attend to for themselves. The ED obtained mouth swabs from the local medical supply store to ensure Med Techs were able to perform appropriate mouth care of residents unable to swish and spit after receiving inhaler treatments. 1/12/22 ED/Care Managers held all staff meeting to re-inservice staff on the following: Resident Rights; the importance of daily mouth care; the importance of appropriate grooming of all residents; the importance of showering residents per shower schedule and as needed- if resident refuses, document and notify Care Manager for follow-up. 1/20/22 Care Managers will update all "who am I" sheets to ensure all caregivers know what is needed to provide care for each resident both in AL and MC. These sheets will be updated as the residents' needs change. They will be reviewed for accuracy when the resident's care plan is updated. 2/27/22	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6889

W5MV11

If continuation sheet 1 of 44

Reviewed and acknowledged - HF 03/01/2022

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D 269	Continued From page 1 infection. -He was a resident in the SCU. -He required total assistance with personal care. -He was non-ambulatory. -He was incontinent of bowel and bladder. Review of Resident #2's previous FL-2 dated 12/08/21 revealed: -Diagnoses included vascular dementia, Alzheimer disease, hemiplegia and hemiparesis, dysphagia, essential hypertension, atherosclerosis, chronic pain, and benign prostatic hyperplasia. -He was intermittently disoriented. -He was semi-ambulatory. Review of Resident #2's Resident Register revealed the date of his admission was 11/11/21. Review of Resident #2's care plan dated 12/15/21 revealed he required limited assistance with eating, toileting, ambulation, bathing, dressing, grooming, and transfers. Observations of the Special Care Unit (SCU) on 01/11/22 at 9:21am revealed he was asleep in his bed with his mouth open while asleep. Observations of the SCU dining room on 01/11/22 at 12:15pm revealed: -Resident #2 was sitting in a wheelchair at a table awaiting his lunch. -Resident #2's hair was uncombed. Review of Resident #2's hospital discharge summary dated 01/07/22 revealed: -Resident #2 was admitted to the hospital on 01/03/22. -His discharge diagnoses included oral thrush (oral thrush is an infection in which the fungus	D 269	Care staff will be sure to round on residents at a minimum of every 2 hours, offering toileting and checking for any needs that may be voiced at that time. 2/27/22 Care Managers will make unit rounds no less than twice daily to ensure personal care and supervision, including ensuring appropriate personal hygiene is occurring for all residents as required. 2/27/22 ED will follow up with Care managers in daily management meeting to ensure care and documentation of care is occurring as required. The team will also follow up on any voiced concerns. 2/27/22 ED will make facility rounds no less than twice daily to ensure personal care of residents is occurring appropriately, and that no resident concerns are voiced that may need follow up. 2/27/22		2/27/22

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D 269	Continued From page 2 Candida albicans accumulates in the mouth). -Resident #2 presented to the hospital after having an episode of vomiting mucus. -He had difficulty enunciating and was somewhat nonverbal. -Resident #2 had oral thrush when he arrived at the ED from the facility and was treated with oral nystatin (nystatin is used to treat fungal infections). Telephone interview with Resident #2's power of attorney (POA) on 01/13/22 at 11:50am revealed: -Resident #2 had a diagnosis of dementia and resided in the SCU since being admitted to the facility on 11/11/21 from a skilled nursing facility. -He was wheelchair bound but self-propelled his wheelchair independently. -When the family members visited Resident #2, after Thanksgiving, he was begging for something to drink because he was thirsty, and the family gave him something to drink from their car. -Resident #2's mouth was dry and had crackers or bread stuck in his mouth and he was not able to swallow. -The POA requested staff get Resident #2 a drink and staff agreed to do so. -The staff failed to provide Resident #2 with a beverage or clean his mouth. -About 2 weeks ago, the family members were visiting Resident #2, the facility was extremely cold, and he did not have on jacket or sweater and complained of being cold and was shaking. -Staff went to get his jacket and Resident #2 was trying to talk to the family members through his mask. -The family members pulled the mask down to better understand what he was saying and were horrified when they saw a large amount of brownish green thick mucus stuck on and in his	D 269			

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D 269	Continued From page 3 mouth, on his nose, his chin, mustache and on the inside of the mask. -When the family members showed a staff, the staff stated he just coughed the mucous up and used the same mask to attempt to wipe the mucous off Resident #2's face. -Since he was admitted to the facility, he had become weak and was unable to self-propel his wheelchair. -He had not been shaved since admitted to the facility and the family members were told by staff he did not want to be shaved (even though he had dementia and required total care) and they did not want to get in trouble for shaving him, which was concerning that the staff would get in trouble for shaving Resident #2. -The resident looked bad. He was never shaved since admission, he had a body odor, his hair was flaky and greasy. He never had on his shoes/bedroom, only socks. -When Resident #2 was admitted to the facility in November 2021, he wore a size 38 pants, but he had lost a tremendous amount of weight loss after admission to the facility. -All his pants and shirts sagged on him. -He had visible muscle loss over his body. -His bones in his chest/arms were much more visible due to weight loss. -He had a big stomach when admitted to the facility, but his stomach was sunk in when admitted to the hospital. -He was "drying up". He was weak and had 'lost' his voice. -He looked as if he was suffering from malnutrition. -He was recently admitted to a local hospital on 01/03/22 and was diagnosed with a severe urinary tract infection and severe dehydration. -He was treated with intravenous (IV) antibiotics and IV fluids.	D 269			

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D 269	Continued From page 4 -The resident was incontinent and wore incontinent briefs, but the staff did not keep him clean and dry. -A family member was upset and tried to talk to the Administrator about their concerns but was told by the Administrator if they did not want Resident #2 there, to take him out. Review of Resident #2's December 2021 point of care history revealed: -It was documented Resident #2's tub bath/shower and shave were completed on 12/04/21-12/30/21. -It was documented Resident #2's sponge bath was completed on 12/06/21-12/27/21. -It was documented Resident #2's hair care was completed from 12/03/21-12/31/21. -It was documented Resident #2's mouth care was completed from 12/02/21-12/31/21 on first shift through third shift. Review of Resident #2's January 2022 point of care history revealed: -It was documented Resident #2's tub bath/shower, shave, and hair care were completed on 01/01/22-01/12/22. -It was documented Resident #2's sponge bath was completed on 01/03/22 and 01/10/22. -It was documented Resident #2's mouth care was completed from 01/01/22 through 01/12/22 on first shift through third shift except for 01/04/22 through 01/06/22 due to the resident's hospitalization. Interview with a personal care aide (PCA) on 01/13/22 at 8:45am revealed: -Resident #2 required total assistance with his personal care which included dressing, bathing, grooming, and feeding. -Resident #2's mouth care was completed	D 269			

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D 269	Continued From page 5 throughout the day every day, she believed at least twice per day. -When she completed his mouth care she would first place a swab in water and then would proceed to clean his mouth out with the swab. -If his mouth care required another swab a different swab would be used. -She had noticed Resident #2 needed more mouth care in the morning because he breathed through his mouth breather and his mouth was drier in the morning. -Residents were given 2 4-ounce (oz) cups of water with each meal. -Resident #2 drank lots of water each shift. -She estimated he maybe drank two 4 oz cups at each meal during her shift at breakfast and at lunchtime. -Evening shift (2:00pm-10:00pm) and night shift (10:00pm-6:00am) would also provide him water. Interview with a second PCA on 01/13/22 at 9:34am revealed: -Resident required the assistance of 2 staff members with all his personal care assistance which included toileting, transfers, bathing, dressing, and grooming. -Resident #2 had whitish material on his tongue, she could not recall the exact date, but she knew it was after he returned from his hospitalization on 01/07/22. Interview with a third PCA on 01/13/22 at 10:10am revealed: -She had observed Resident #2 received mouth care from the medication aide (MA) with a mouth swab after his inhaler was administered to him. -When she provided mouth care to Resident #2, she would assess if he had food in his mouth. -She would use a toothbrush when providing his mouth care after both meals.	D 269			

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D 269	Continued From page 6 -Resident #2 required 2-person assistance with his personal care. Interview with the medication aide/Supervisor (MA/S) on 01/13/22 at 10:45am revealed: -Resident #2 required the assistance of 2 staff members with his activities of daily living. -It depended on the resident's ability, which varied day to day if he needed to be fed by a staff member. -It was the PCAs responsibility to provide Resident #2 mouth care every shift and to report anything abnormal. -There was nothing reported to her when his mouth care was completed. Interview with the Special Care Unit Coordinator (SCUC) on 01/13/22 at 12:08pm revealed: -The MA would use a washcloth to clean Resident #2's mouth after the administration of his daily inhaler. -She expected the PCAs to complete Resident #2's mouthcare every shift and as needed. -On 01/03/22, she observed Resident #2 vomit mucous, she cleaned his mouth after he vomited and only observed the remnants of his vomit. -She did not observe the presence of thrush in his mouth and nothing had been reported to her. Telephone interview with Resident #2's primary care provider (PCP) on 01/13/22 at 1:22pm revealed: -She expected residents to receive mouth care every day at least twice per day at the facility. -She was not sure the staff at the facility would have known Resident #2 had thrush if they had observed it prior to his hospitalization. -She was not surprised when Resident #2 was diagnosed with oral thrush when he was admitted to the hospital on 01/03/22.	D 269			

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D 269	Continued From page 7 -He had a fungal infection in his groin area prior to his hospitalization (she could not recall the date). -When a resident had fungal infection in a different location for example the groin area it could also appear in another location. Interview with the Administrator on 01/13/22 at 5:00pm revealed: -When a resident received oral care, a resident's teeth should be brushed twice a day beginning on first shift and a resident's dentures would be cleaned and soaked during night shift. -For a resident without teeth, oral care would be completed twice a day, the resident's mouth would be cleaned twice a day with a mouth swab and as necessary. -She would expect if a PCA observed an abnormality during the completion of oral care, for example, the observation of thrush, the PCA would report it immediately to the MA and then the MA report to the SCUC so the resident's PCP could be notified. -She expected residents to receive at least 12 ounces of water per meal. -If a resident was not eating or drinking at mealtimes, feeding assistance should be first offered. -If the resident still did not want to eat after feeding assistance was offered, it was the responsibility of the PCA and the MA to notify the SCUC and the resident's PCP immediately the same day if there were acute changes in a resident's status such as decreased oral intake or altered mental status. -When a resident was not drinking an adequate amount of water, dehydration could occur. -If a resident was not eating, failure to thrive was a possibility. -It would be important to notify the resident's PCP	D 269			

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D 269	Continued From page 8 to investigate this and come up with medical interventions based upon the PCP orders. Resident #2's November 2021 point of care history from 11/11/21 to 11/30/21 was requested on 01/13/22 at 8:11am but was not received prior to survey exit on 01/13/22. Based on observations, interviews and record review it was determined Resident #2 was not interviewable. Refer to the interview with the SCUC on 01/11/22 at 1:10pm. Refer to the interview with a PCA on 01/13/22 at 8:45am. Refer to the interview with a second PCA on 01/13/22 at 9:34am. Refer to the interview with a third PCA on 01/13/22 at 10:09am. Refer to the interview with the MA/S on 01/13/22 at 10:45am. Refer to the second interview with the SCUC on 01/13/22 at 12:08pm. Refer to the interview with the Administrator on 01/13/22 at 5:00pm. 2. a. Review of Resident #4's current FL-2 dated 09/14/21 revealed: -Diagnoses included dementia, Acute Metabolic Encephalopathy, hypernatremia, anemia and elevated serum creatinine. -He was ambulatory with assistance. -He needed personal care assistance with	D 269			

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D 269	Continued From page 9 bathing and dressing. Review of Resident #4's current care plan dated 11/30/21 revealed: -He was sometimes disoriented and needed reminders. -He required total dependence with toileting. -He required extensive assistance with ambulation, bathing, dressing, grooming/personal hygiene and transfers. Observations of the Special Care Unit (SCU) on 01/11/22 at 8:43am - 10:00am revealed: -There were 11 residents and 1 staff in the TV room on the SCU. -Resident #4 was in a wheelchair in the TV room with his pants and brief down around his knees and his hair uncombed. Review of Resident #4's November 2021 point of care history revealed: -It was documented Resident #4's tub bath/shower and shave were completed on 11/01/21-11/29/21. -It was documented Resident #4's sponge bath was completed on 11/02/21-11/30/21. -It was documented Resident #4's hair care was completed from 11/01/21-11/30/21. Review of Resident #4's December 2021 point of care history revealed: -It was documented Resident #4's tub bath/shower was completed on 12/01/21-12/31/21. -It was documented Resident #4's sponge bath was completed on 12/02/21-12/30/21. -It was documented Resident #4's shave was completed on 12/01/21-12/29/21. -It was documented Resident #4's hair care was completed on 12/01/21.	D 269			

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D 269	Continued From page 10 Review of Resident #4's January 2022 point of care history revealed: -It was documented Resident #4's tub bath/shower and shave were completed on 01/03/22- 01/12/22. -It was documented Resident #4's sponge bath was completed on 01/01/22- 01/11/22. -There was no documentation Resident #4's hair care was completed from 01/01/22-01/13/22. Interview with a personal care aide (PCA) on 01/13/22 at 8:45am revealed: -He required total assistance with his personal care. -An aide from hospice came to the facility to provide total assistance with his personal care which included his shower and his hair care and dressing the resident (the frequency of the hospice visits was not provided). -Staff was responsible to provide Resident #4's personal care assistance which included bathing, dressing, and grooming if the hospice aide did not come to the facility. -Resident #4's "Who Am I" document did not match his current level of assistance needed and she had informed the Special Care Unit Coordinator (SCUC) a while ago, she estimated about 2 months ago. Interview with a second PCA on 01/13/22 at 9:34am revealed: -Resident #4 required the assistance of 2 staff members with his personal care. -A hospice aide came to the facility to complete his personal care three days per week. -Staff would be responsible to provide Resident #4's personal care assistance which included bathing, dressing, and grooming if the hospice aide did not come to the facility.	D 269			

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D 269	Continued From page 11 Interview with a third PCA on 01/13/22 at 10:10am revealed: -A hospice aide provided total assistance with Resident #4's personal care tasks three, she was not sure the frequency of the hospice aide's visits to the facility. -He required the assistance of 1-2 staff members with his personal care on the days not provided by the hospice aide. Interview with the medication aide/Supervisor (MA/S) on 01/13/22 at 10:45am revealed: -Resident #4 required the assistance of 1-2 staff members with his personal care. -A hospice aide provided total assistance with Resident #4's personal care tasks at the facility two-three times per week. -When the hospice aide came to facility it was considered "extra help" the facility was still responsible for his personal care. Telephone interview with a hospice nurse on 01/13/22 at 11:33am revealed: -Resident #4 required 1 - 2 person assist with completing personal care tasks. -There was a hospice PCA that came to the facility three times a week and assisted Resident #4 with showers, oral care, washing and combing hair and dressing. -It was the responsibility of the facility's staff to ensure that grooming tasks were completed on the days that the hospice PCA was not at the facility. Based on observations, interviews and record review it was determined Resident #4 was not interviewable. Attempted telephone with Resident #4's	D 269		

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D 269	Continued From page 12 responsible party on 01/13/22 at 11:30am was unsuccessful. Refer to the interview with the SCUC on 01/11/22 at 1:10pm. Refer to the interview with a PCA on 01/13/22 at 8:45am. Refer to the interview with a second PCA on 01/13/22 at 9:34am. Refer to the interview with a third PCA on 01/13/22 at 10:09am. Refer to the interview with the MA/S on 01/13/22 at 10:45am. Refer to the second interview with the SCUC on 01/13/22 at 12:08pm. Refer to the interview with the Administrator on 01/13/22 at 5:00pm. b. Review of Resident #7's current FL-2 dated 11/17/21 revealed: -Diagnoses included dementia, hypertension, unilateral edema of lower extremities, thrombocytopenia, and bipolar disorder. -He was a resident in the Special Care Unit (SCU). -He was constantly disoriented. -He required personal care assistance with bathing and dressing. -He was ambulatory. -He was incontinent of bowel and bladder. Review of Resident #7's care plan dated 01/13/22 revealed: -He required limited assistance with dressing.	D 269			

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NAME OF PROVIDER OR SUPPLIER THE MAGNOLIA			STREET ADDRESS, CITY, STATE, ZIP CODE 213 FOREST TRAIL CLINTON, NC 28328		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 269	Continued From page 13 -He required total assistance with grooming and hygiene. Observations of the SCU on 01/11/22 at 8:43am - 10:00am revealed: -Resident #7 was seated in the TV room and had scruffy facial hair, his pajama pants were on backwards and he was wearing an adult brief that was saturated and sagging. -At 9:31am, Resident #7 was ambulating in the hallway and continued to have scruffy facial hair, his pajama pants on backwards and a saggy adult brief. Review of Resident #7's November 2021 point of care history revealed: -It was documented Resident #7's tub bath/shower and shave were completed on 11/01/21-11/29/21. -It was documented Resident #7's sponge bath was completed on 11/02/21-11/30/21. -There was an entry for a shave to be completed once a day on Monday, Wednesday, and Friday. Review of Resident #7's December 2021 point of care history revealed: -It was documented Resident #7's tub bath/shower and shave were completed on 12/01/21-12/31/21. -It was documented Resident #7's sponge bath was completed on 12/02/21-12/30/21. Review of Resident #7's January 2022 point of care history revealed: -It was documented Resident #7's tub bath/shower and shave were completed on 01/03/22-01/12/22. -It was documented Resident #7's sponge bath was completed on 01/01/22- 01/11/22.	D 269			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL082022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 01/13/2022
NAME OF PROVIDER OR SUPPLIER THE MAGNOLIA		STREET ADDRESS, CITY, STATE, ZIP CODE: 213 FOREST TRAIL CLINTON, NC 28328			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 269	Continued From page 14 Interview with a personal care aide (PCA) on 01/13/22 at 8:45am revealed Resident #7 required total assistance with his personal care except for feeding. Interview with a second PCA on 01/13/22 at 10:10am revealed: -Resident #7 required the assistance of 2 staff members with his personal care which included toileting, bathing, dressing, and grooming. -He was independent with feeding and ambulation. Interview with the medication aide/Supervisor (MA/S) on 01/13/22 at 10:45am revealed required total assistance from 1-2 staff members with his personal care except for feeding. Based on observations, interviews and record review it was determined Resident #7 was not interviewable. Refer to the interview with the SCUC on 01/11/22 at 1:10pm. Refer to the interview with a PCA on 01/13/22 at 8:45am. Refer to the interview with a second PCA on 01/13/22 at 9:34am. Refer to the interview with a third PCA on 01/13/22 at 10:09am. Refer to the interview with the MA/S on 01/13/22 at 10:45am. Refer to the second interview with the SCUC on 01/13/22 at 12:08pm.	D 269			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL082022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 01/13/2022
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D 269	Continued From page 15 Refer to the interview with the Administrator on 01/13/22 at 5:00pm. c. Review of Resident #8's current FL-2 dated 12/15/21 revealed: -Diagnoses included dementia, diabetes mellitus type II, hyperglycemia, and hypertension. -She was a resident in the Special Care Unit (SCU). -She was constantly disoriented. -She required total assistance with personal care. -She was ambulatory with a rollator. -She was incontinent of bowel and bladder. Review of Resident #8's care plan dated 01/13/22 revealed she required limited assistance with dressing and grooming and hygiene. Observations of the SCU dining room on 01/11/22 at 12:23pm revealed: -Resident #8 sat at a table with another resident awaiting lunch meal service. -Her hair was uncombed. Review of Resident #8's November 2021 point of care history revealed: -It was documented Resident #8's tub bath/shower, bathing/upper body, and hair were completed on 11/02/21-11/30/21. -It was documented Resident #8's sponge bath was completed on 11/01/21-11/29/21. -It was documented Resident #8's bathing/upper body was completed on 11/02/21-11/30/21. Review of Resident #8's December 2021 point of care history revealed: -It was documented Resident #8's tub bath/shower, bathing/upper body, and hair care were completed on 12/02/21-12/30/21. -It was documented Resident #8's sponge bath	D 269			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL082022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 01/13/2022
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D 269	Continued From page 16 was completed on 12/01/21-12/31/21. Review of Resident #8's January 2022 point of care history revealed: -It was documented Resident #8's tub bath/shower, bathing/upper body, hair care were completed on 01/01/22- 01/12/22. -It was documented Resident #8's sponge bath was completed on 01/02/22- 01/12/22. Interview with a personal care aide (PCA) on 01/13/22 at 8:45am revealed Resident #8 required total assistance with her personal care which included bathing, dressing, and grooming. Interview with a second PCA on 01/13/22 at 9:34am revealed: -Resident #8 required the assistance of 1 staff member with her person care. -She could wash her face and the top half of her body. -She required total assistance for toileting. -She could comb her own hair, staff would assist her as needed with her hair care. Interview with a third PCA on 01/13/22 at 10:10am revealed: -Resident #8 required assistance with her shower. -The PCAs would wash her private area, her back, her feet, would shampoo and comb her hair. -She would brush her own teeth. Interview with the medication aide/Supervisor (MA/S) on 01/13/22 at 10:45am revealed: -Resident #8 did not need extensive help with her personal care. -Staff would give her washcloth and she was able to assist with the areas she could reach.	D 269			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL082022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 01/13/2022
NAME OF PROVIDER OR SUPPLIER THE MAGNOLIA			STREET ADDRESS, CITY, STATE, ZIP CODE 213 FOREST TRAIL CLINTON, NC 28328		
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D 269	Continued From page 17 -Staff would provide help with washing her hair and combing her hair. Based on observations, interviews and record review it was determined Resident #8 was not interviewable. Refer to the interview with the SCUC on 01/11/22 at 1:10pm. Refer to the interview with a PCA on 01/13/22 at 8:45am. Refer to the interview with a second PCA on 01/13/22 at 9:34am. Refer to the interview with a third PCA on 01/13/22 at 10:09am. Refer to the interview with the MA/S on 01/13/22 at 10:45am. Refer to the second interview with the SCUC on 01/13/22 at 12:08pm. Refer to the interview with the Administrator on 01/13/22 at 5:00pm. d. Review of Resident #9's current FL-2 dated 11/17/21 revealed: -Diagnoses included dementia, high cholesterol, cerebrovascular accident, and vitamin B12 deficiency. -She was a resident in the Special Care Unit (SCU). -She was intermittently disoriented. -She required personal care assistance with bathing and dressing. -She was ambulatory. -She was incontinent of bladder.	D 269			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL082022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 01/13/2022
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D 269	Continued From page 18 Review of Resident #9's care plan dated 11/10/21 revealed she required limited assistance with dressing and grooming and hygiene. Observations of Resident #9 in the SCU dining room on 01/11/22 at 12:25pm revealed her hair was uncombed and greasy. Review of Resident #9's November 2021 point of care history revealed: -It was documented Resident #9's tub bath/shower, bathing/upper and lower body, hair care were completed on 11/11/21-11/30/21. -It was documented Resident #9's sponge bath was completed on 11/12/21-11/29/21. Based on record review, Resident #9's December 2021 point of care history log was requested and was not received by survey exit. Review of Resident #9's January 2022 point of care history revealed: -It was documented Resident #9's tub bath/shower and bathing/upper and lower body were completed on 01/01/22- 01/11/22. -It was documented Resident #9's sponge bath was completed on 01/02/22-01/12/22. -It was documented that Resident #9's hair was shampooed, or hair care was completed from 01/01/22 - 01/12/22. Interview with a personal care aide (PCA) on 01/13/22 at 8:45am revealed: -Resident #9 would brush her teeth and wash her face. -Staff was responsible to wash her hair and to comb her hair. -She preferred to place her hair in a ponytail.	D 269			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL082022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 01/13/2022
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D 269	Continued From page 19 Interview with a second PCA on 01/13/22 at 9:34am revealed: -Resident #9 required physical assistance with her personal care; staff would remind her to go to the bathroom and gave her a washcloth to encourage her to wash her face. -Resident #9 could brush her own hair and put her hair up in a ponytail. Interview with a third PCA on 01/13/22 at 10:10am revealed: -She required assistance with washing her back and legs. -She was able to wash her hair; and she was able to comb her own hair. Interview with the medication aide/Supervisor (MA/S) on 01/13/22 at 10:45am revealed: -Resident #9 required the assistance of 1 staff member with her personal care. -At times staff member would have to encourage her to shower. -She was able to comb her own hair. -Staff was responsible to help with areas that were missed, for example, her hair. Based on observations, interviews and record review it was determined Resident #9 was not interviewable. Refer to the interview with the SCUC on 01/11/22 at 1:10pm. Refer to the interview with a PCA on 01/13/22 at 8:45am. Refer to the interview with a second PCA on 01/13/22 at 9:34am. Refer to the interview with a third PCA on	D 269			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL082022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 01/13/2022
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D 269	Continued From page 20 01/13/22 at 10:09am. Refer to the interview with the MA/S on 01/13/22 at 10:45am. Refer to the second interview with the SCUC on 01/13/22 at 12:08pm. Refer to the interview with the Administrator on 01/13/22 at 5:00pm. e. Review of Resident #10's current FL-2 dated 12/01/21 revealed: -Diagnoses included Alzheimer's dementia, syncope, diabetes mellitus type with polyneuropathy, epilepsy, and severe scoliosis/kyphoscoliosis. -She was a resident in the Special Care Unit (SCU). -She was intermittently disoriented. -She required personal care assistance with bathing and dressing. -She was ambulatory with a rollator. Review of Resident #10's care plan dated 12/02/21 revealed she required limited assistance with dressing and grooming and hygiene. Observations of the SCU on 01/11/22 at 12:25pm revealed: -Resident #10 was sitting at table within the SCU dining room awaiting lunch service. -Her hair was uncombed, and several hair strands were standing up on the back of her head. Observations of the SCU on 01/12/22 at 12:22pm revealed Resident #10's hair was uncombed, and several strands were standing up on the back of her head.	D 269			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL082022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 01/13/2022
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D 269	Continued From page 21 Review of Resident #10's November 2021 point of care history revealed: -It was documented Resident #10's tub bath/shower and bathing/upper body were completed on 11/01/21-11/29/21. -It was documented Resident #10's sponge bath was completed on 11/02/21-11/30/21. -It was documented that Resident #10's hair was shampooed, or hair care was completed from 11/01/21 - 11/30/21. Review of Resident #10's December 2021 point of care history revealed: -It was documented Resident #10's tub bath/shower, bathing/upper and lower body, and hair care were completed on 12/01/21-12/31/21. -It was documented Resident #10's sponge bath was completed on 12/02/21-12/30/21. Review of Resident #10's January 2022 point of care history revealed: -It was documented Resident #10's tub bath/shower, bathing/upper and lower body was completed on 01/03/22- 01/12/22. -It was documented Resident #10's sponge bath was completed on 01/01/22- 01/12/22. -It was documented that Resident #10's hair was shampooed, or hair care was completed from 01/01/22 - 01/12/22. Interview with a personal care aide (PCA) on 01/13/22 at 8:45am revealed: -Resident #10 required limited assistance with her personal care. -She would wash herself during her shower which included her hair; assistance was provided to wash her feet and her back. -She would also comb her own hair. -She did not work with Resident #10 on Tuesday,	D 269			

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D 269	Continued From page 22 01/11/22. -Resident stayed in her bed a lot and watched TV which could explain her hair looking uncombed on Tuesday, 01/11/22. Interview with a second PCA on 01/13/22 at 9:34am revealed: -Resident #10 required verbal encouragement from staff to complete the personal care tasks of bathing and feeding, the staff would wash her back on assigned shower days. -Resident #10 was independent with grooming. Interview with a third PCA on 01/13/22 at 10:10am revealed: -She required assistance with washing her back, her feet, her hair, and with fastening her undergarments. -She would brush her own hair, and if it was out of place the PCAs would address. Interview with the medication aide/Supervisor (MA/S) on 01/13/22 at 10:45am revealed: -She could wash certain body parts her face, her arms, her hair and her chest area. -On shower days, the PCAs would assist her with washing her legs, her feet, and back. -If her hair was out of place, it was expected staff to assist her to comb her hair. Based on observations, interviews and record review it was determined Resident #10 was not interviewable. Refer to the interview with the SCUC on 01/11/22 at 1:10pm. Refer to the interview with a PCA on 01/13/22 at 8:45am.	D 269			

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D 269	Continued From page 23 Refer to the interview with a second PCA on 01/13/22 at 9:34am. Refer to the interview with a third PCA on 01/13/22 at 10:09am. Refer to the interview with the MA/S on 01/13/22 at 10:45am. Refer to the second interview with the SCUC on 01/13/22 at 12:08pm. Refer to the interview with the Administrator on 01/13/22 at 5:00pm. f. Review of Resident #3's current FL-2 dated 05/05/21 revealed: -Diagnoses included dementia, hypertension (HTN), mood disorder, and hypothyroidism. -She was constantly disoriented. -She was ambulatory and had wandering behaviors. -She required personal care assistance with bathing, feeding and dressing. Review of Resident #3's current Care Plan dated 12/02/21 revealed: -She was verbally abusive, uncooperative, sociable and aggressive. -She was continent but required assistance with hygiene. -She was independent with ambulation and did not require assistive devices. -She required limited assistance with bathing, dressing, grooming and hygiene. -She required supervision with transfers. Observations of the Special Care Unit (SCU) on 01/11/22 at 8:43am - 10:00am revealed: -There were 11 residents and 1 staff in the TV	D 269		

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D 269	Continued From page 24 room on the SCU. -Resident #3 was in a wheelchair in the TV room with her hair uncombed and a soiled bandage to her left hand. Review of Resident #3's November 2021 point of care history revealed: -It was documented Resident #3's tub bath/shower was completed on 11/01/21-11/29/21. -It was documented Resident #3's sponge bath was completed on 11/02/21-11/30/21. -It was documented Resident #3's hair care was completed from 11/01/21-11/30/21. Review of Resident #3's December 2021 point of care history revealed: -It was documented Resident #3's tub bath/shower and hair care were completed on 12/01/21-12/31/21. -It was documented Resident #3's sponge bath was completed on 12/02/21-12/30/21. Review of Resident #3's January 2022 point of care history revealed: -It was documented Resident #3's tub bath/shower was completed on 01/03/22-01/12/22. -It was documented Resident #3's sponge bath was completed on 01/01/22-01/11/22. -It was documented Resident #3's hair care was completed from 01/01/22-01/12/22. Interview with a personal care aide (PCA) on 01/13/22 at 8:45am revealed: -Resident #3 was receiving hospice services (the date of admission was not provided). -She now required total assistance with her personal care. -Staff would be responsible to provide Resident	D 269		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL082022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 01/13/2022
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D 269	Continued From page 25 #3's personal care assistance which included bathing, dressing, and grooming if the hospice aide did not come to the facility. -Resident #3's "Who Am I" did not match her current level of assistance needed and she had informed the Special Care Unit Coordinator a while ago, she estimated a couple of weeks ago. Interview with a second PCA on 01/13/22 at 9:34am revealed: -Resident #3 required total assistance from 1 staff member with her personal care. -She had declined in the last few weeks she required now total assistance with personal care. Interview with a third PCA on 01/13/22 at 10:10am revealed: -Resident #3 required total assistance from 1 staff member with her personal care. -At times, she could walk a few steps, but she was not stable walking on her own. -Resident #3 had a physical decline recently but she could not recall the dates her decline. Telephone interview with a hospice nurse on 01/13/22 at 11:33am revealed: -Resident #3 required 1 person assist with completing personal care tasks. -There was a hospice PCA that came to the facility three times a week and assisted Resident #3 with showers, oral care, washing and combing hair and dressing. -It was the responsibility of the facility's staff to ensure that grooming tasks were completed on the days that the hospice PCA was not at the facility. Based on observations, interviews and record review it was determined Resident #3 was not interviewable.	D 269			

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D 269	Continued From page 26 Attempted telephone with Resident #3's responsible party on 01/13/22 at 11:30am was unsuccessful. Refer to the interview with the SCUC on 01/11/22 at 1:10pm. Refer to the interview with a PCA on 01/13/22 at 8:45am. Refer to the interview with a second PCA on 01/13/22 at 9:34am. Refer to the interview with a third PCA on 01/13/22 at 10:09am. Refer to the interview with the MA/S on 01/13/22 at 10:45am. Refer to the second interview with the SCUC on 01/13/22 at 12:08pm. Refer to the interview with the Administrator on 01/13/22 at 5:00pm. Interview with the Special Care Unit Coordinator (SCUC) on 01/11/22 at 1:10pm revealed: -It was the responsibility of the staff to assist residents with their scheduled showers every other day and as needed. -On the resident's shower days, oral care was provided, their hair was washed and combed, nails were trimmed, and shaving was provided. -On the resident's non-shower days, it was the responsibility of the staff to ensure that oral care was completed, their hair was combed, and residents were dressed appropriately for the day. Interview with a personal care aide (PCA) on	D 269		

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D 269	Continued From page 27 01/13/22 at 8:45am revealed: -The residents' level of assistance with their personal care would be outlined on a document titled, "Who Am I?", posted on the inside door of the resident's closet within their room or she would speak with the Special Care Unit Coordinator (SCUC) or the lead Medication Aide/Supervisor (MA/S). -If the document titled, "Who Am I?", did not match, the resident's current level of assistance she would bring this to the attention of the SCUC. -Any changes with the residents' level of assistance with their personal care would also be discussed at weekly meetings facilitated by the SCUC. -When she arrived for her shift, she would look at the resident assignment sheet. -The residents' personal care assistance started at 6:00am. -She would first assist the resident out of bed and obtain the resident's hygiene box containing their toiletries. -The residents were showered every other day and the residents were shaved twice a week. -She would wash the resident's face, brush teeth, swab the resident's mouth if they did not have teeth, wipe the resident down if was not the resident's shower day. -On shower days, the resident's hair would be washed and on non-shower days their hair would be combed. -Incontinent care was completed every two hours by staff. Interview with a second PCA on 01/13/22 at 9:34am revealed: -She would go with the flow to the determine the resident's level of assistance with their personal care. -She would also reference the document titled,	D 269			

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D 269	Continued From page 28 "Who Am I" posted within the resident's room. -If the "Who Am I" did not match the resident's current level of assistance she would report the discrepancies to the SCUC. -When she arrived for her shift, she would look at the resident assignment sheet and receive report from the off-going PCA. -Residents were assisted with their showers every other day. -If it was not a resident's shower day, she would bring the resident to the bathroom and provide them a washcloth to freshen up to wash their face, armpits, and private areas. -She would also brush their hair, brush their teeth, and if the resident did not have teeth, mouth care would be provided with a pink mouth swab. -On 01/11/22, her shift did not start until 2pm. Interview with a third PCA on 01/13/22 at 10:09am revealed: -When she arrived for her shift, she would look at the resident assignment sheet. -She tried to complete all her residents' showers before breakfast. -Residents' showers were assisted with their showers every other day. -If it was not the resident's assigned shower day; she would wash them down which included their face and their bodies, hair was combed, and their teeth were brushed. -Mouth care for residents without teeth happened after breakfast to remove food particles with a mouth swab or toothbrush. -A new employee at the facility would become aware of a residents' level of assistance with their personal care from observations from their trainer. -Another reference was a document titled, "Who Am I" posted within the resident's room, however	D 269			

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D 269	Continued From page 29 sometimes it was not available, because it would get torn off the resident's closet door. Interview with the MA/S on 01/13/22 at 10:45am revealed: -She was a MA/S and primarily worked in the SCU on first shift (6:00am-2:00pm). -She may need to assist the PCAs with a resident's personal care or could be switched to work as a PCA if a staff member called out then the SCUC would administer medications. -The MA/S would set up staff assignments for the shift and direct staff members which residents would receive showers during the shift. -The MA/S and the SCUC would check all residents' point of care history every day prior to the shift ending. -If the MA/S or the SCUC observed a personal care task not completed, for example a resident's hair not combed or washed or mouth care not completed, she would immediately ask the PCA to complete the personal care task. -Residents were expected to receive mouth/oral/denture care every shift, it was part of their personal care on shower and non-shower days. -If a resident did not have teeth the resident's mouth care would be completed by the PCA with a washcloth or mouth swab. -The document titled, "Who Am I?" was also a reference fir all staff members to determine a resident's level of assistance with personal care. -The document titled, "Who Am I?" was updated by the SCUC and both MA/S would assist as requested by the SCUC. Second interview with the SCUC on 01/13/22 at 12:08pm revealed: -She rounded the SCU daily to verify if a resident's personal care was being completed.	D 269			

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D 269	Continued From page 30 -There were several areas and times she would monitor a resident was provided help with their personal care. -When in a resident's room she would complete a general overview of the resident's appearance from observation, check the resident's mouth to confirm their mouth care was completed, she would check a resident's brief to confirm if incontinent care was being completed. -The second time she would observe the completeness of a resident's personal care could be when she was administering medications to the residents. -The third time she would observe the completeness of resident's personal care was at mealtimes. -The fourth time she would observe the completeness of a resident's personal care was when she completed a walk through the TV room. -If there was an observation that a resident did not have mouth care completed or if their hair was not combed, she would tell the PCA to complete the personal care task as soon as it was observed by her. -If a resident had teeth, the PCAs were expected to brush their teeth every shift. -If a resident had dentures, the PCAs were expected to brush them every shift and soak them during night shift. -If a resident did not have teeth the PCAs would still get a toothbrush wet, apply toothpaste, and massage their gums or use a mouth swab every shift. -She expected the PCAs if they observed a resident with facial hair then they were expected to the shave the resident that day. Interview with the Administrator on 01/13/22 at 5:00pm revealed: -She expected residents to be provided	D 269		

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D 273	Continued From page 32 The findings are: Review of Resident #2's current FL-2 dated 01/06/22 revealed: -Diagnoses included dementia, hypernatremia, acute kidney injury, dehydration, and urinary tract infection. -He was a resident in the Special Care Unit (SCU). -His weight was 171 pounds (lbs.). -His height was 5 feet 11 inches. Review of Resident #2's previous FL-2 dated 12/08/21 revealed diagnoses included vascular dementia, Alzheimer disease, hemiplegia and hemiparesis, dysphagia, essential hypertension, atherosclerosis, chronic pain, and benign prostatic hyperplasia. Review of Resident #2's Resident Register revealed the date of his admission was 11/11/21. Observation of Resident #2's being weighed on 01/12/22 at 10:43am revealed: -The weight of wheelchair was 44.0 lbs. -The weight of Resident #2 sitting in the wheelchair was 210.5 lbs. -Resident #2's weight was 166 lbs. Telephone interview with Resident #2's power of attorney on 01/13/21 at 11:50am revealed: -Resident #2 had a diagnosis of dementia and resided in the SCU since being admitted to the facility on 11/11/21. -When Resident #2 was admitted to the facility in November 2021, he wore a size 38 pants, but he had lost a tremendous amount of weight after admission to the facility. -All his pants and shirts sagged on him.	D 273	stay and proper documentation of this weight. This was discussed during the med tech meeting. Care Managers completed 100% chart audits to review for any health care concerns that require PCP notification (i.e. vital signs, weights, blood sugars, and outside referrals). 1/21/22 Care Managers will monitor all residents weights at least monthly or more frequently per MD orders, and report any significant change weight loss or gain defined as 5% in 30 days or 10% in 6 months (or per specific MD parameters). 2/27/22 Care Manager to follow-up on all new admit/readmit documentation within 24 hours to ensure a baseline weight has been obtained and documented. They will also ensure appropriate notifications have occurred and are documented. 2/27/22 ED/Care Managers will discuss new admit/readmit residents in management meeting to ensure any needed follow-up has occurred. 2/27/22 ED/Care Managers will discuss residents with weight loss/gain weekly in the at risk meeting to ensure interventions are appropriate and are effective. 2/27/22 Care Managers will complete a minimum of 2 chart audits weekly to ensure all orders/referrals have been processed and implemented appropriately. Completed audits will be submitted to the ED at the end of the week for review. 2/27/22		

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D 273	Continued From page 33 -He had visible muscle loss over his body, the family members could see his bones in his chest/arms. -He had a big stomach when admitted to the facility, but his stomach was sunk in when admitted to the hospital. -He was "drying up". -He was weak and had 'lost' his voice. -He was recently admitted to a local hospital on 01/03/22 and was diagnosed with a severe urinary tract infection and severe dehydration. -He was treated with intravenous (IV) antibiotics and IV fluids. Review of Resident #2's primary care provider (PCP) order dated 11/15/21 revealed an order to obtain monthly vital signs on the 13th and the 16th of the month. Review of Resident #2's November 2021 electronic medication administration record (eMAR) revealed: -There was an entry for monthly vital signs (temperature, pulse, respirations, blood pressure, and weight) to be obtained on the 13th and the 16th of the month during second shift (3:00pm-11:00pm). -On 11/16/21, his weight was 185 lbs. Review of Resident #2's December 2021 eMAR revealed: -There was an entry for monthly vital signs (temperature, pulse, respirations, blood pressure, and weight) to be obtained on the 13th and the 16th of the month during second shift (3:00pm-11:00pm). -On 12/13/21, his weight was 180 lbs. -On 12/16/21, his weight was 180 lbs. Review of Resident #2's lab work dated 11/26/21	D 273		

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D 273	Continued From page 34 at 11:04am revealed: -His Na level was 147. -His Cl level was 108. -His BUN level was 25.2. -His Cr level was 0.88. -His albumin level was 3.8. Review of Resident #2's hospital discharge summary dated 01/07/22 revealed: -Resident #2 was admitted to the hospital on 01/03/22. -His discharge diagnoses included hypernatremia, acute kidney injury, dehydration, urinary tract infection, hematuria, and oral thrush (Hypernatremia is a high concentration of sodium in the blood, acute kidney injury is condition in which the kidneys suddenly cannot filter waste from the blood, hematuria is blood in the urine, and oral thrush is an infection in which the fungus Candida albicans accumulates in the mouth). -His discharge diagnoses included dementia, chronic obstructive pulmonary disease, and coronary artery disease which were indicated as chronic. -His lab work was significant for hypernatremia, a sodium (Na) level of 166 and blood urea nitrogen (BUN)/creatinine (Cr) levels of 38/1.51, (the reference range for Na is 135 to 145, the reference range for BUN is 7 to 21, and the reference range for Cr is 0.9 to 1.3). -His lab work on 01/07/22 included an albumin level of 2.1 (protein malnutrition is associated with a serum albumin level of less than 3.5 g/dL, the reference range for albumin is 3.4 to 5.4). -In the ED, he only reported he felt cold. -He was started on antibiotics and his hypernatremia improved with fluids and electrolyte supplements. -Oral thrush was found on 01/03/22 and was treated with oral nystatin (nystatin is used to treat	D 273			

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D 273	Continued From page 35 fungal infections). -Discharge instructions outlined it was very important that Resident #2 received and be confirmed to drink at least 12 ounces (1.5 cups) of water with each meal. If this did not happen, he would eventually return to the same state that brought him here. Review of Resident #2's primary care provider (PCP) notification dated 12/22/21 revealed: -Resident #2's weight in November 2021 was 185 lbs. -Resident #2's weight in December 2021 was 180 lbs. -There was an order to please continue to monitor. -The order was signed and dated by Resident #2's PCP on 12/29/21. Review of Resident #2's progress notes from 07/11/21-01/11/22 revealed: -An Incident/Accident report dated 01/01/22 at 9:21am documented Resident #2 refused breakfast and a message was left for Resident #2's PCP. -There was no documentation Resident #2's PCP was notified after 12/22/21 of his weight loss or that he was not eating or drinking. Interview with the medication aide/Supervisor (MA/S) on 01/13/22 at 10:45am revealed: -The MA was responsible to notify the resident's PCP if the resident had a weight change. -The Special Care Unit Coordinator (SCUC) would notify a resident's PCP by phone or fax if a resident's weight loss or gain was greater than 5 lbs. -The SCUC could initiate a repeat weight for the resident also prior to the PCP notification. -She was not sure if she had observed Resident	D 273			

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D 273	Continued From page 36 #2's clothes fitting loose fitting or if he had any weight loss recently. -Resident #2's level of feeding assistance depended on the day. -Some days he could fed himself without any staff assistance, other days he required staff assistance. -If he was observed during mealtime to not be eating or drinking, staff was expected to give verbal encouragement and provide feeding assistance. Interview with the SCUC on 01/13/22 at 12:10pm revealed: -She was responsible to notify the resident's PCP via telephone or fax of any resident change in condition, for example, a weight loss or gain of 5 lbs. or greater. -An additional weight was not obtained for Resident #2 when he returned from the hospital the evening of 01/07/22 because that was not part of the facility's current process. -She had not notified Resident #2's PCP there was a weight difference of 9 lbs. from his weight of 180 lbs. obtained on 12/13/21 and on 12/16/21 to the weight of 171 lbs. obtained on 01/06/21 which was included on the hospital FL-2. -She had not notified Resident #2's PCP there was a weight difference of 14 lbs. from his current weight (166 lbs.) obtained on 01/12/22 with his weight of 180 lbs. obtained on 12/13/21 and on 12/16/21. -She had not notified Resident #2's PCP from 01/12/22 to today, 01/13/22, because she was not aware of Resident #2's previous weight of 180 lbs. -Resident #2's PCP should have been notified because his weight loss was greater than 5 lbs. -It was important to notify a resident's PCP of a 5 lb weight loss or gain because it may indicate the	D 273			

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D 273	Continued From page 37 resident had an underlying health issue, they were not aware of. -The weight loss or gain could affect the resident's overall general health. Telephone interview with Resident #2's PCP on 01/13/22 at 1:22pm revealed: -She was not notified Resident #2's weight was 171 lbs. when he returned to the facility on 01/07/22 after his hospital stay from 01/03/22-01/07/22. -She was not notified Resident #2's weight was 166 lbs. on 01/12/22. -She would have expected to be notified of these weight losses as they were pretty significant change from Resident #2's weight of 180 lbs. in December 2021. -The 14 lbs. weight loss was an 8% weight loss in a month. -She expected to be notified by the facility with anything more than 3% which was based on the standard 10% in 3 months or less. -She was not aware of his albumin level of 2.1 but this was a direct correlation to his weight loss. -There were no notifications or discussions from the facility, Resident #2 had not been eating or drinking at mealtimes. -She would have expected Resident #2 to receive encouragement to eat and drink water and if not effective to be notified. -The PCP notification was important so she could provide medical interventions for Resident #2, for example, a supplement, an appetite stimulant, the initiation of anti-depressant, or a possible referral to a gastrointestinal specialty provider. Interview with the Administrator on 01/13/22 at 5:00pm revealed: -She expected staff to notify a resident's PCP with any change in a resident's health status	D 273		

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D 273	Continued From page 38 immediately, which meant the same day. -The method of PCP notification could be by fax or phone but was dependent on the resident's situation. -The PCP should be notified by phone if there was a high or low fingerstick blood glucose, change in mental status, and a weight loss (no additional details provided). -It was important to notify the resident's PCP immediately to obtain a medical intervention, for example, a medication adjustment, an order for lab work, or an order for a urinalysis. -She had not been made aware if Resident #2 had not been eating or drinking at mealtimes. -If a resident was observed by staff to not be eating or drinking at mealtimes, the resident should be given verbal encouragement or feeding assistance. -She had concerns for Resident #2's due to his weight loss of 14 lbs. over a month. -Her concerns included dehydration, skin breakdown, or another hospitalization. The facility failed to notify the provider of a 9 lb. weight loss from 12/13/21 to 01/07/22, the resident had a recent hospitalization with a documented weight of 171 lbs. and a low albumin level of 2.1 which is significant for protein malnutrition; the resident continued to lose an additional 5 lbs. from 01/07/22 to 01/12/22 for a total of 14 lbs. weight loss or 9% of his total body weight in one month and the provider was not notified. The facility's failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G S 131D-34 on 01/13/22 for this violation.	D 273			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL082022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/13/2022
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 39 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 27, 2022.	D 273		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the residents were treated with dignity and respect for 1 of 6 sampled residents (#6) during mealtime. The findings are: Review of Resident #6's current FL-2 dated 11/17/21 revealed: -Diagnoses included dementia, constipation, peripheral vascular disease (PVD), hypertension (HTN), history of breast cancer and history of falls. -She was a resident in the Special Care Unit (SCU). -She was intermittently confused. -She had wandering behaviors and was semi-ambulatory. -She required personal care assistance with bathing, feeding and dressing. Review of Resident #6's record revealed there was no care plan available. Observations in the SCU dining room on 01/11/22 at 12:44pm revealed:	D 338	The Magnolia shall ensure that the rights of all residents guaranteed under G.S. 131D-21, are maintained and may be exercised without hindrance. ED re-inserviced staff on resident rights during all-staff meetings. Housekeeper/PCA will receive training and revalidation prior to assisting with resident feeding/care again. ED/Care Managers re-inserviced care staff on the proper way to provide feeding assistance to residents during staff meeting. ED/Care Managers/Designee will randomly make rounds through the dining room during mealtimes to ensure appropriate feeding techniques are being utilized, and staff is present as required.	1/20/22 2/17/22 2/27/22 1/20/22 2/27/22

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D 338	Continued From page 40 -Resident #6 was sitting at a table with another resident during lunch service. -Resident #6's back was not resting against the back of the chair, her head was leaning forward and was positioned in front of both shoulders, and she had kyphosis (kyphosis is a forward rounding of the back). -The housekeeper manager/personal care aide (PCA) walked over to Resident #6's table to provide her feeding assistance. -The housekeeper manager/PCA care aide gave 2 spoonfuls of ground meat and mashed potatoes to Resident #6 twice while she stood next to the table. -The medication aide/Supervisor (MA/S) moved a chair over to Resident #6's table for the housekeeper manager/PCA to sit while providing feeding assistance. Observations on 01/11/22 from 12:50-1:05pm revealed: -The housekeeper manager/PCA's right hand was pushing Resident #6's left shoulder back towards the back of the chair while attempting to provide feeding assistance. -Resident #6 said "ouch." -The housekeeper manager/PCA continued to provide Resident #6 feeding assistance. -The palm of the housekeeper manager/PCA's right hand was resting on Resident #6's forehead while providing feeding assistance. -Resident #6 said, "she was sore." -The housekeeper manager/PCA continued to provide Resident #6 feeding assistance. -There was a total of 5 times the housekeeper manager/PCA placed her right hand on Resident #6's left shoulder while providing feeding assistance. -There was a total of 3 times the housekeeper manager/PCA placed the palm of her right hand	D 338			

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D 338	Continued From page 41 on Resident #6's forehead while providing feeding assistance. Interview with the Special Care Unit Coordinator (SCUC) on 01/11/22 at 1:10pm revealed: -The staff that assisted Resident #6 with the meal worked primarily in the housekeeping and laundry departments. -The staff had trained and worked as a personal care aide (PCA) several years ago and worked as a PCA "every blue moon." -It was the responsibility of the staff to assist residents with meals at eye level and in an unhurried manner. -It was the responsibility of the staff to cue or prompt residents to sit in an upright position for meals. -It was the responsibility of the staff to assist residents to an upright position if they were unable to do so after verbal cueing and prompting. -The staff was not supposed to physically hold or force a resident while assisting with repositioning. Interview with the housekeeper manager/PCA on 01/11/22 at 1:37pm revealed: -She was the lead housekeeper; she primarily worked in laundry but would work where she was needed in the facility. -On 01/11/22, she was assigned to work in laundry, but was moved to work as a PCA in the SCU. -She had been trained as a PCA since 2005 and part of her PCA training was how to provide feeding assistance to residents. -Her feeding assistance training included to not stand while providing feeding assistance to a resident. -There was no reason given why she was standing next to Resident #6 upon the initiation of	D 338		

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D 338	Continued From page 42 providing feeding assistance to Resident #6. -She had placed her hands-on Resident #6's shoulder and forehead because she wanted Resident #6 to sit up straight while being fed her lunch because Resident #6 was leaning forward. -It was not appropriate of her to place her hands-on Resident #6's shoulder and forehead while feeding her lunch. -It was not appropriate of her to place her hands-on Resident #6's shoulder and forehead while feeding her lunch because she could have given Resident #6 a bruise or hurt her. -She did hear Resident #6 say "ouch" and that she was "sore" during lunch service. -There was no reason given why she did not stop after Resident #6 said "ouch" and stated she was "sore." Interview with the Administrator on 01/13/22 at 5:00pm revealed: -She expected the staff to provide verbal cueing to residents to assist them with positioning. -If a resident was not able to position themselves after the verbal cueing, the staff were to slowly assist the resident with positioning to prevent or decrease discomfort. -A staff member should not place their hands on a resident's shoulder or forehead due to the possibility of hurting the resident. Based on observations, interviews and record review it was determined Resident #6 was not interviewable.	D 338			
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are	D912	See above POC responses		

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D912	Continued From page 43 adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to health care. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 1 of 5 sampled residents (#2) related to not notifying the provider of weight loss for a resident with a recent hospitalization. [Refer to Tag D 273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)].	D912			

Forte, Hope

From: The Magnolia, ED -Eaton, Jill <director@sampsonseniors.com>
Sent: Wednesday, February 23, 2022 4:23 PM
To: Forte, Hope
Cc: Reka Green; Rakishia Peterson
Subject: [External] 1/13/22 POC
Attachments: 01132022 POC.pdf

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Please see attached.

Jill Braswell / Executive Director/ The Magnolia/ E: director.sampsonseniors.com/ P: (910)592-7506