STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115004	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Manor Methodist Nsg C	2001 South Lee Street Americus, GA 31709

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, staff interviews, record review, and review of the facility policy titled, Care Plans-Comprehensive Person-Centered the facility failed to implement appropriate individualized interventions on the comprehensive care plan for a resident requiring oxygen therapy management for one of 24 residents (R) (R65) receiving oxygen. This deficient practice had the potential to place the residents at risk for unmet care needs.Findings include:Review of the undated policy Care Plans-Comprehensive Person-Centered revealed under procedural guidelines: . 2. The care plan is developed from the resident assessment (MDS (minimum data set) and in coordination with the attending physician's regimen of care.Review of the electronic medical record (EMR) for R65 revealed diagnoses that included butare not limited to unspecified asthma, uncomplicated.Review of Physician Orders dated 03/24/2026 for R65 revealed orders for oxygen at two liters per minute (LPM) via nasal canula (NC).Review of the care plan for R65 revealed the resident required oxygen therapy related to respiratory disease. Interventions failed to include individualized or specific care interventions that would give the resident the highest practicable physical level, including medical interventions related to the physician order regarding the administration of medications as prescribed or per standing order.Interview on 04/30/2026 at 12:30 PM with MDS Coordinator AA revealed that R65's oxygen care plan interventions should include individualized medical interventions related to the flow rate so that clinical staff were aware of the prescribed rate so they are able to monitor for hypoxia (low oxygen level) and the resident's drive to breath. She confirmed that the resident's care plan was lacking specific/individualized interventions related to oxygen such as follow physician order for flow rate. She revealed that after she was notified the resident's flow rate was on the wrong setting during the survey, it prompted her to review the care plan, and she updated it to include appropriate interventions related to oxygen including Administer oxygen at rate prescribed by medical provider.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations and staff interviews, the facility failed to ensure an environment free from potential hazards by not removing aerosol cans from the bedside for two of 50 sampled residents (R) (R34 and R37). This deficient practice increased the risk of potential accidents. Findings include: 1. Observations on 04/28/2026 at 11:42 AM, 04/29/2026 at 10:33 AM, and 04/30/2026 at 10:12 AM of R37's room revealed one aerosol container (air freshener) placed on top of the nightstand located next to R37's bed. During an interview on 04/30/2026 at 10:43 AM, Nurse Supervisor Licensed Practical Nurse (LPN) GG and Certified Nursing Assistant (CNA) HH confirmed the aerosol container was present in R37's room. Both staff stated that aerosol containers were not permitted in resident rooms due to safety concerns for residents who wander. CNA HH and LPN GG immediately removed the aerosol container from R37's room at the time of the interview. During an interview on 04/30/2026 at 11:48 AM, the Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON) confirmed the aerosol container was present in R37's room and stated that aerosol items were not permitted in resident rooms. 2. Observation conducted on 04/28/2026 at 11:42 AM, 04/29/2026 at 9:29 AM, and 04/30/2026 at 10:37 AM in R34's room revealed five aerosol containers (deodorant spray and dry shampoo hairspray) placed on top of one of two nightstands located at R34's bedside. During an interview on 04/30/2026 at 10:43 AM, LPN GG and CNA FF confirmed that aerosol containers were present in R34's room. Both staff confirmed aerosol containers were not permitted in resident rooms, particularly due to safety concerns for residents who wander. CNA FF and LPN GG immediately removed the aerosol containers from R34's room at the time of the interview. During an interview on 04/30/2026 at 11:41 AM, the Infection Preventionist (IP) confirmed that aerosol containers were present in R34's rooms and revealed aerosol containers were not permitted in resident rooms. During an interview on 04/30/2026 at 11:48 AM, the Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON) confirmed aerosol containers were present in R34's room and stated aerosol containers were not permitted in resident care areas.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff interviews, and review of the facility's policy titled, Oxygen Therapy, the facility failed to ensure the physician's order for oxygen administration was followed for one of 24 Residents (R) (R65) reviewed for oxygen administration. The deficient practice had the potential to place the resident at risk for medical complications, unmet needs and a diminished quality of life.Findings include:Review of the facility's undated policy titled Oxygen Administration under the section titled Intent revealed: It is the intent of (corporate name) facilities to ensure that oxygen is administered appropriately to residents to improve oxygenation and provide comfort to residents experiencing respiratory difficulties.Review of the electronic medical record (EMR) for R65 revealed diagnoses that included but are not limited to unspecified asthma, uncomplicated.Review of 65's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed, Sections C (Cognitive Patterns), a Brief Interview of Mental Status (BIMS) score of 00, indicating R65 was unable to complete, Section O (Special Treatments and Programs), respiratory therapy.Review of Physician Orders for R65 dated 03/24/2026 revealed orders for oxygen at two liters per minute via nasal canula.Observations on 04/28/2026 at 11:18 AM and 3:08 PM, and 04/29/2026 at 9:04 AM revealed R65's oxygen rate set at 3 LPM. Observation and rounding on 04/29/2026 at 10:08 AM with the Director of Nursing (DON) confirmed R65's oxygen order was for 2 LPM. The DON verified the resident's oxygen rate was set at 3 LPM instead of 2 LPM. When shown pictures from observations from 4/28/2026 at 11:18 AM and 3:08 PM with oxygen rate set on 3 LPM, the DON revealed nurses should check the oxygen rate to match the physician order at least once a shift, usually during medication pass.Interview on 04/29/2026 at 10:10 AM with Registered Nurse (RN) BB revealed she was the nurse assigned to R65 on 04/29/2026. She stated she completed the resident's medication pass earlier and admitted she did not verify the residents concentrator to confirm the oxygen rate was on the prescribed setting and confirmed the order was for 2 LPM.