STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115124	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Manor of Columbus Nursing Center - East	2010 Warm Springs Rd Columbus, GA 31904

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46691 Based on staff interviews and record review, the facility failed to submit for a Preadmission Screening and Resident Review (PASRR) Level II after a new mental health diagnosis was added for one of three residents (R) (R17) reviewed for PASRR Level II. This deficient practice had the potential to affect the level of care and services provided for R17. Findings include: The Director of Nursing (DON) revealed there was no facility policy for PASRR. Review of the electronic medical record (EMR) revealed that R17 was admitted on [DATE] without a significant mental health diagnosis. Review of R17's annual Minimum Data Set (MDS) dated [DATE] revealed section A (Identification Information) documented the resident had not been evaluated by Level II PASRR, section I (Active Diagnoses) included and documented bipolar disorder, and section O (Special Treatments and Programs) documented no therapies or treatments were received. Review of R17's Face Sheet revealed current diagnoses included bipolar disorder, current episode depressed dated 2/14/2024, and bipolar disorder in partial remission dated 8/8/2023. Review of the EMR revealed a PASRR Level I dated 1/11/2023 did not include the diagnosis of bipolar. Further review of the EMR revealed there was no PASSR Level II. Interview on 7/13/2024 at 10:50 am, the Admission Coordinator stated R17 was admitted to the facility on [DATE] with a PASRR Level I and did not have a serious mental illness diagnosis at admission. She stated the diagnosis of bipolar was added on 8/8/2023. She further stated the Social Service Director (SSD) normally received the provider notes that added the diagnosis and should have submitted for a PASRR Level II at that time. The SSD was unavailable for an interview. (continued on next page)

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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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 7/13/2024 at 11:35 am, the Director of Nursing (DON) stated the SSD was responsible for submission for a PASRR Level II when a new serious mental illness or other qualifying diagnosis was added to a resident's diagnosis list. She stated the SSD received the provider notes and should review them to ensure new diagnoses were communicated to the clinical staff and for submission of a PASRR Level II. She further revealed new diagnoses were discussed in the clinical morning meeting and the SSD attended the meetings. The DON stated it was an oversight that a submission for a PASRR Level II was not submitted for R17 after the diagnosis of bipolar was added. She confirmed the failure to submit for a PASRR Level II in a timely manner after a serious mental illness or other qualifying diagnosis had the potential to prevent residents from receiving necessary services for serious mental illness or other qualifying diagnosis and have a negative impact on a resident's clinical and psychosocial condition.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33548 Based on staff interviews, record review, and review of facility policies titled, Assessing Vital Signs, and Care Planning-Interdisciplinary Team, the facility failed to follow the comprehensive Care Plan regarding weekly weights for one of 33 residents (R) (R82) in the sample. Findings include: Review of the facility policy titled, Assessing Vital Signs dated February 2019 revealed Weight: Each resident should be weighed upon admission and re-admission to the facility. All weights should be recorded in designated location of the residents Chart. Residents shall be weighed monthly or more often when clinically indicated. Review of the facility policy titled, Care Planning-Interdisciplinary Team, updated October 2016, under Intent, it is the intent of Magnolia Manor facilities to provide care to our residents that is person-centered, and consistent with Resident Rights. The facilities Interdisciplinary Team shall be responsible for the development and implementation of a person-centered comprehensive care plan for our residents. Under Procedural Guidelines number 2. The care plan is based on the resident's comprehensive assessment and is developed by the Interdisciplinary Team which includes, but is not necessarily limited to the following, E. Food and nutrition services. Review of the medical record revealed R82 was admitted to the facility on [DATE] and had diagnoses that included but not limited to type 2 diabetes, chronic kidney disease stage 3, and Alzheimer's disease. Review of the comprehensive care plan revealed a Nutrition Care Plan had been developed and included an intervention to weigh weekly with a start date of 5/15/2024. Review of the vital signs section of the medical record revealed a weights section which indicated the last recorded weight for R82 was on 5/29/2024. Interview on 7/13/2024 at 2:15 pm with the Director of Nursing (DON), after review of the medial record, confirmed that the last weight for R82 was performed and recorded on 5/29/2024, and R82 has not been weighed since. The DON revealed that R82's care plan listed weekly weights as a nutrition intervention. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additional interview with the DON on 7/14/2024 at 10:10 am revealed R82 was placed on weekly weights for a month after admission because R82 had weight fluctuations. The DON stated that R82's weights were discussed during PAR (performance and accountability reporting) meetings. The PAR team determined that R82 needed weekly weights, and the care plan was updated to indicate an intervention to weigh weekly. The DON revealed that once R82's weights stabilized, the PAR team decided that discussion and weekly weights were no longer required and R82 would be discharged from PAR review. Discussion for weight fluctuations for R82 was discontinued, and he was changed to monthly weights. Further interview with the DON revealed that the lead Certified Nursing Assistant (CNA) EE was responsible for residents requiring weekly weights, and restorative nursing was responsible for residents on monthly weights. The DON stated that the lead CNA and the restorative nursing CNA attend the PAR meetings which are held weekly. If a resident goes from weekly weights to monthly weights those team members should adjust their resident list at that time. The DON revealed that R82 should have been weighed weekly after his last weight on 5/29/2024. Interview on 7/14/2024 at 10:40 am with CNA EE revealed that she was responsible for any resident that required weekly weights. The CNA stated that she did attend the weekly PAR meetings and when resident's weights were discussed she will adjust her weekly weight list during the meeting. The CNA revealed that restorative nursing attended the PAR meetings and once the team determined that a resident no longer required weekly weights, restorative knew they needed to add to the monthly weight list. The CNA revealed if she is not able to attend the PAR meeting, the DON will let her know which residents have been added to the weekly weight list and which residents no longer require weekly weights. The CNA stated that if restorative nursing does not attend the PAR meeting and a resident is discharged from requiring weekly weights, she will communicate that change from weekly weights to monthly weights. The CNA revealed that she must have missed communicated with restorative nursing and should have notified them to add R82 to the monthly weight list.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33548 Based on staff interviews, record review, and review of the facility's policy titled, Scope of Assessments, the facility failed to complete an admission nutrition assessment for one of five residents (R) (R82). The deficient practice had the potential to prevent R82 from receiving required nutrients in accordance with the resident's nutritional needs. Findings include: Review of the facility's policy titled, Scope of Assessments dated March 2014 revealed under Procedural Guidelines number 11. Nutritional assessments should be completed on admission, at least quarterly, and as needed based on the resident's condition and dietary needs. Review of the medical record revealed R82 was admitted to the facility on [DATE] and had diagnoses that included but not limited to, type 2 diabetes, chronic kidney disease stage 3, and Alzheimer's disease. Review of the physician orders revealed R82 had a diet order of CCD (controlled carbohydrate diet) renal. R82 was also ordered Prostat nutrition supplement 30 mL (milliliters) three times a day for low albumin and total protein level. Review of the medical record revealed, an admission nutrition assessment completed by the registered dietitian or nursing could not be found. Interview on 7/13/2024 at 2:15 pm the Director of Nursing (DON) was unable to locate an admission nutritional assessment for R82. The DON revealed that she would reach out to the registered dietitian to see if an admission nutrition assessment was completed. The DON confirmed that with no admission nutrition assessment in the medical record, nursing staff were not able to review for dietary guidance. Interview on 7/14/2024 at 10:10 am with the DON revealed the registered dietitian was not able to find a nutrition assessment for R82. The DON stated that she expected the dietitian to complete an admission nutrition assessment shortly after the resident admitted to the facility. The DON revealed that nutrition assessments were documented directly in the medical record system where data could be entered using a template. Continued interview revealed that the IDT (Interdisciplinary Team) reviewed new admission medical records to ensure all admission assessments were completed by each department. If there was no assessment the IDT should notify the responsible department/person to complete. The DON stated that IDT should have contacted the registered dietitian to complete the admission nutrition assessment for R82.

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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** 46691 Based on observations, staff interviews, record review, and review of the facility's policy titled, Oxygen Therapy, the facility failed to ensure oxygen (O2) was administered according to physician order for two of 15 residents (R) (R5 and R59) receiving oxygen. In addition, the facility failed to ensure respiratory equipment was maintained in a sanitary manner for one of 15 residents (R11) receiving oxygen. The deficient practices had the potential to place R5, R59, and R11 at risk for medical complications, unmet needs, and a diminished quality of life. Findings include: Review of the facility policy titled, Oxygen Therapy, dated March 2024, revealed the Intent was, It is the intent of Magnolia Manor facilities to ensure that oxygen is administered appropriately to residents to improve oxygenation and provide comfort to residents experiencing respiratory difficulties. The Procedural Guidelines, Oxygen Therapy - Mask and Nasal Cannula section stated 5. The external filter on the oxygen concentrators should be checked weekly and cleaned as needed. 1. Review of R5's diagnoses included chronic pulmonary edema, dependence on oxygen, and chronic respiratory failure. Review of R5's annual Minimum Data Set (MDS) assessment dated [DATE] revealed section GG (Functional Abilities and Goals) documented R5 was dependent on staff for activities of daily living (ADLs), and section O (Special Treatments and Programs) documented R5 received oxygen therapy while a resident. Review of the care plan revealed a focus area that R5 required the use of oxygen continuously. Interventions included administering oxygen therapy as ordered. Review of the active physician's orders revealed R5 had an order dated 2/6/2023 for oxygen at 2 liters per minute via nasal cannula continuously. Observations on 7/12/2024 at 8:40 am and 3:05 pm, and on 7/13/2024 at 7:50 am revealed R5 receiving oxygen via a nasal cannula with the flow rate set at 3.5 liters per minute. Observation on 7/14/2024 at 8:10 am with Registered Nurse (RN) BB, confirmed R5 was receiving oxygen via nasal cannula at 3.5 liters per minute, and the physician's order was for oxygen at 2 liters per minute via nasal cannula. RN BB stated that depending on the resident's diagnosis and condition, receiving too much oxygen could cause harmful effects for the resident. She stated the nurse normally checked resident's oxygen settings every shift and ensured the flow rate was set to the physician's orders. She further stated oxygen equipment was checked during daily rounds but was unsure if the flow rate was checked. RN BB revealed R5 was unable to adjust the flow rate of the oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 7/13/2024 at 11:15 am, the Director of Nursing (DON) confirmed oxygen flow rates should be set to the physician's order, and the nurses were responsible for ensuring the flow rate was set to the ordered rate. She stated the nurse should check the flow rate every shift and ensure it was being administered at the ordered flow rate. She further stated administering oxygen at a rate higher than ordered by the physician could cause harmful side effects for the resident. 47146 2. Review of the electronic medical record (EMR) revealed R59 was admitted to the facility on [DATE] and pertinent diagnoses included but was not limited to, heart failure, cardiomegaly, chronic pulmonary edema, pleural effusion, and chronic obstructive pulmonary disease. Review of R59's Admission MDS assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 11, which indicated R59 had moderate cognitive impairment. Review of the Care Area Assessment (CAA) on the admission MDS assessment dated [DATE] triggered care planning areas of cognitive loss/dementia, visual function, Activities of Daily Living (ADL) functional/rehabilitation potential, urinary incontinence and indwelling catheter, falls, nutritional status, and pressure ulcer. Review of R59's care plan initiated on 6/24/2024 did not include interventions related to oxygen use. Review of the EMR revealed physician's orders for R59 included but was not limited to, oxygen at two liters per minute via nasal cannula continuously dated 7/12/2024. Observations made on 7/12/2024 at 9:42 am and 3:10 pm, and on 7/13/2024 at 8:00 am, R59 was lying in bed with oxygen via nasal cannula, the flow rate was set at four liters per minute. Interview on 7/13/2024 at 8:25 am, and observation at that time of R59's oxygen flow rate, RN BB confirmed the oxygen flow meter for R59's oxygen was set at four liters per minute. RN BB revealed R59 was recently admitted to hospice services and was just ordered oxygen therapy at two liters per minute via nasal cannula on 7/12/2024 and she confirmed R59's oxygen should be on two liters per minute. RN BB also confirmed that the order in the EMR was for oxygen at two liters per minute via nasal cannula. Interview on 7/13/2024 at 9:45 am with the Director of Nursing revealed her expectation was that her staff follow the physician orders for oxygen administration and the flow rate should be what the physician ordered. She revealed that once orders are received the care plan should be addressed and updated. She revealed this practice could result in a resident experiencing respiratory distress and if the care plan does not reflect the use of oxygen could result in the team not knowing the parameters of the physician orders related to oxygen use and not providing care as ordered. 35180 3. Review of R11's medical record revealed an order dated 6/11/2024 for continuous oxygen via nasal cannula (NC) at 2 liters per minute to maintain oxygen saturation above 90%. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of R11's oxygen concentrator on 7/12/2024 at 10:00 am, and 7/13/2024 at 8:38 am revealed that the external oxygen filter on the oxygen concentrator was visibly dirty, with accumulated dust over the entire filter. Observation of R11 on 7/12/2024 at 10:00 am and 7/13/2024 at 8:38 am revealed he was receiving oxygen via NC per MD orders. Interview with the LPN AA on 7/13/2024 at 8:43 am, she revealed she was the nurse for R11 on 7/13/2024 and had administered his medications earlier in the morning. LPN AA reported that the exterior oxygen filters on the concentrators were to be cleaned weekly and as needed. She acknowledged that R11's oxygen filter was dirty and said it was the nursing staff's responsibility to ensure it was cleaned. Interview with the DON on 7/13/2024 at 1:50 pm, she acknowledged the external oxygen filter on R11's oxygen concentrator was dirty and had accumulated dust covering the filter. The DON said she expected staff to clean the outside of the concentrators weekly and assess as needed to ensure the filter was clean. The DON added the exterior filter should always be clean.