

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 06/27/2024
NAME OF PROVIDER OR SUPPLIER Magnolia Manor of Columbus Nursing Center - East		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>21213</p> <p>Based on staff interviews and record review, the facility failed to ensure that medications were administered as care planned and ordered, for one of three residents (R) (R1). The deficient practice had the potential to prevent R1 from obtaining care in accordance with their care needs.</p> <p>Findings include:</p> <p>R1 was admitted to the facility with diagnoses of but not limited to type 2 diabetes mellitus. Review of the clinical record revealed that R1 had a nutrition care plan, dated 1/17/2023, that included the diagnosis of diabetes. The nutrition care plan included an intervention, dated 2/22/2024, for nursing staff to administer medication as ordered.</p> <p>Review of R1's physician's orders revealed an order, dated 12/18/2023, for 6 units of Novolog insulin to be administered before meals. There was also an order, dated 12/18/2023, for 30 units of Lantus insulin to be administered daily, in the morning for a diagnosis of diabetes. However, facility nursing staff failed to administer insulin medication as ordered and as care planned on 6/10/2024.</p> <p>Review of a Patient Instructions for Hospital Procedure form, dated 5/9/2024, for R1, from the Cardiologist office, revealed that R1 was scheduled for a vascular procedure, an Atherectomy with runoff (procedure to remove plaque buildup and open narrow or blocked arteries), on 6/10/2024. The instructions on the form included to hold insulin the day of the procedure.</p> <p>Review of a 6/7/2024 7:13 pm nurse's note revealed that pre-operation orders were noted for a surgical procedure scheduled for 6/10/2024. The nurse's note documented that the orders included not to give diabetic medications or insulin the day of the procedure.</p> <p>Review of R1's June 2024 electronic Medication Administration Record (eMAR) revealed the order of do not give any diabetic medications or insulin the day the procedure, 6/10/2024 was documented. However, further review of the June 2024 eMAR revealed that licensed nursing staff administered 6 units of Novolog insulin at 11:30 am and 4:30 pm and 30 units of Lantus insulin at 12:00 pm on 6/10/2024.</p> <p>During an interview on 6/25/2024 at 4:50 pm, DON stated that even though there was an order to hold insulin on 6/10/2024, there was a computer input error. When she reviewed the hold history, the Novolog insulin had been put on hold for 6/10/2024, but the time of the hold was from 12 am to 10 am, instead of the whole day, in error.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cross reference to F684

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>21213</p> <p>Based on staff interviews, and record review, the facility failed to ensure that medications were administered, and fingerstick blood sugar levels were obtained, as ordered by the physician, for one of three residents (R) (R1). The deficient practice had the potential to increase the probability of R16 blood glucose levels not to be maintained according to the residents' care needs.</p> <p>Findings included:</p> <p>R1 was admitted to the facility with a diagnosis of type 2 diabetes mellitus. Review of R1's physician's orders revealed an order, dated 12/18/2023, for 6 units of Novolog insulin to be administered before meals. There was also an order, dated 12/18/2023, for 30 units of Lantus insulin to be administered daily, in the morning for a diagnosis of diabetes. However, facility nursing staff failed to administer insulin medication as ordered on 6/10/2024.</p> <p>Review of a Patient Instructions for Hospital Procedure form, dated 5/9/2024, for R1, from the Cardiologist office, revealed that R1 was scheduled for a vascular procedure, an Atherectomy with run off (procedure to remove plaque buildup and open narrow or blocked arteries), on 6/10/2024. The instructions on the form included to hold insulin the day of the procedure.</p> <p>Review of a 6/7/2024 7:13 pm nurse's note revealed that pre-operation orders were noted for a surgical procedure scheduled for 6/10/2024. The nurse's note documented that the orders included not give diabetic medications or insulin the day of the procedure.</p> <p>During an interview on 6/26/2024 at 3:05 pm, the Director of Nursing (DON) stated that transportation picked R1 up on 6/10/2024 at 6:29 am for his procedure that day and returned to the facility at 12 noon. Review of the surgical center procedure notes revealed that R1 underwent an Atherectomy/Runoff on 6/10/2024.</p> <p>Review of R1's June 2024 electronic Medication Administration Record (eMAR) revealed the order of do not give any diabetic medications or insulin the day of the procedure, 6/10/2024 was documented. However, further review of the June 2024 eMAR revealed that licensed nursing staff administered 6 units of Novolog insulin at 3:49 pm and 6:30 pm and 30 units of Lantus insulin at 12:00 pm on 6/10/2024.</p> <p>During an interview on 6/25/2024 at 4:50 pm, DON stated that even though there was an order to hold insulin on 6/10/2024, there was a computer input error. When she reviewed the hold history, the Novolog insulin had been put on hold for 6/10/2024, but the time of the hold was from 12 am to 10am, instead of the whole day, in error.</p> <p>Further review of R1's clinical record revealed a physician's order, dated 12/18/2023, for licensed nursing staff to obtain finger stick blood sugar (FSBS) levels before meals and at bedtime.</p> <p>Review of the December 2023 through June 2024 eMARs revealed that FSBS levels were obtained at 6:00 am, 11:30 am, and 4:30 pm. However, there was no bedtime FSBS level scheduled or obtained until after surveyor inquiry on 6/18/2024.</p> <p>(continued on next page)</p>		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/20/2024 at 1:00 pm, the DON stated there was no evidence of the bedtime FSBS reading being scheduled on the eMAR or done.		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>21213</p> <p>Provide and implement an infection prevention and control program.</p> <p>Based on staff interviews, record reviews, and review of the facility policies titled, Infection Prevention and Control, and COVID-19 Response, the facility failed to maintain an infection control program that included thorough and complete surveillance for one of 16 residents (R) (R16), who tested positive for COVID-19.</p> <p>Findings include:</p> <p>Review of the facility policy titled, Infection Prevention and Control, revision and approval date of February 2020. Under Procedural Guidelines number 4. Maintains a record of incidents and corrective actions related to infections.</p> <p>The facility also had a COVID-19 Response policy with a revision and approval date of July 2023. The policy's Documentation section number 2. Resident test results must be maintained in the resident's medical record, 9. A log should be kept for all resident and employee testing.</p> <p>Record review for R16 revealed a nurse's note entry dated 1/24/2024 at 12:47 am that documented R16 was positive for COVID and had no symptoms. The nurse's note further documented that R16's vital signs were stable, R16 denied pain or discomfort, there was no acute respiratory distress, and the plan of care continued to be in progress. A 1/25/2024 at 1:46 am Registered Dietician note also documented that R16 was diagnosed with COVID-19.</p> <p>Record review for R16 revealed a care plan problem, dated 1/31/2024, that R16 was at high risk for contracting COVID-19 due to risk factors of hypertension. The goal of the care plan was that R16 would be free from COVID-19 complication that required hospitalization , with an intervention start date of 1/23/2024.</p> <p>During an interview on 6/25/2024 at 4:11 pm the Director of Nursing (DON) stated that R16 and her roommate (R2) both tested positive for COVID-19 and remained in the room together.</p> <p>Although R16's clinical record included documentation of her positive COVID-19 status, she was not included in the facility's infection control surveillance information.</p> <p>Review of the January 2024 Line Listing of Resident Infections, a part of the facility's infection control program, and review of the facility line list (for 2024) specifically for COVID-19 positive residents, revealed that R16 was not included in either tracking log.</p> <p>During an interview on 6/27/2024 at 4:30 pm, the DON stated that there was no evidence of a COVID-19 testing sheet for R16 for the 1/24/2024 positive COVID-19 test.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>21213</p> <p>Based on staff interviews, record review, and review of the facility policy titled, Infection Prevention and Control, the facility failed to ensure that the Pneumococcal vaccine was administered to three of 18 residents (R) (R12, R13, and R16).</p> <p>Findings include:</p> <p>Review of the facility policy titled, Infection Prevention and Control revision and approval date of February 2020. Under section titled, Influenza and Pneumococcal Immunization number 1. Each resident or resident representative must receive education regarding the benefits and potential side effects from the Pneumococcal immunization. 3. Each resident will be offered the vaccine on admission, and 5b. documentation must include if the resident received the immunization.</p> <p>1. Review of R12's clinical record and facility vaccination information revealed a Pneumococcal Polysaccharide Vaccine (PPSV23) Informed Consent, signed and dated 10/14/2022. The form documented that R12 consented to receiving the pneumococcal vaccine. However, there was no evidence in the clinical record that the vaccine had been administered. During the interview on 6/27/2024 at 4:30 pm, the DON stated that she could not find evidence of the pneumonia vaccine being given to go with the consent.</p> <p>2. Review of R13's clinical record and facility vaccination information revealed a Pneumococcal Immunization Informed Consent form, signed and dated 10/17/2022. The form documented that R13 consented to receive the pneumococcal vaccine. However, there was no evidence in the clinical record that the vaccine had been administered. During the interview on 6/27/2024 at 4:30 pm, the DON stated that she could not find evidence of the pneumonia vaccine being given to go with the consent.</p> <p>3. Review of R16's clinical record and facility vaccination information revealed a Pneumococcal Immunization Informed Consent form, signed and dated 12/1/2023. The form documented that R13's responsible party consented to her receiving the pneumococcal vaccine. However, there was no evidence in the clinical record that the vaccine had been administered.</p> <p>During an interview on 6/27/2024 at 4:30 pm, when the Director of Nursing (DON) was asked about the process for influenza and pneumococcal vaccinations, she responded that the assigned nurse is to offer the vaccine and administer once the consent is obtained. When the vaccine is administered, it is to be documented on the electronic Medication Administration Record (eMAR). The Infection Preventionist (the Assistant Director of Nursing) oversees that process. The unit managers also assist with obtaining vaccination consent and communication to the assigned nurse. DON stated that she could not find evidence of the pneumonia vaccine being given to go with the consent.</p>		