STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115553	A. Building B. Wing	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Manor of Midway	652 North Coastal Highway 17 Midway, GA 31320

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 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review, and a review of the facility policies titled Admissions and Medication Orders, the facility failed to protect one of 33 sampled residents (R) (R4) with allergies. Harm was identified to have occurred on 9/24/2025 when R4 was administered Bactrim DS (an antibiotic medication) that was listed as a known allergy for the resident, resulting in an allergic reaction to the medication (flushing (feeling hot), redness, and rash).Findings included:A review of the facility's policy titled Admissions, reviewed and updated in October 2016, revealed that it is the intent of the facility for the charge nurse to record information, including but not limited to the following, in the designated place (nurses' notes, admission nurse assessment, etc) . any known allergies.A review of the facility's policy titled Medication Orders, reviewed and updated in October 2017, revealed that medications are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe. Verbal orders are received by a licensed nurse, pharmacist, or other authorized by state law to do so. under section of new verbal orders, the nurse will transcribe the order.verbally repeat the order back to the prescriber for verification and clarity, and then note the read back and verified on the order.A review of medical records revealed that R4 was admitted to the facility on [DATE] from an acute care facility. R4's diagnoses included but were not limited to spinal stenosis, cervical region, diabetes mellitus, essential hypertension, peripheral vascular disease, constipation, urinary retention, arthrodesis, and neuromuscular dysfunction of the bladder. R4's allergies on admission included naproxen, acetaminophen, sulfamethoxazole, metoprolol, penicillins, and Symbicort.A review of R4's medication administration records revealed that R4 received the first dose of Bactrim was 9/24/2025 at 9:00 pm and the second dose of Bactrim was 9/25/2025 at 9 am.A review of medical records revealed that Licensed Practical Nurse (LPN) Unit Manager AA contacted the provider at 9/24/2025 at 3:23 pm, related to R4 was experiencing right flank pain and foul-smelling urine. LPN FF entered a telephone order and bypassed the safety alert for Bactrim DS at 9/24/2025 at 4:44 pm.During an interview on 10/7/2025 at 3:30 pm, LPN Unit Manager AA revealed that she put in the order (Bactrim DS) late that evening. She stated that in the EMR that the order form asks for drug name, route, time, and provider name. She stated there were safety alerts and denied seeing a safety alert. She was unsure if the evening nurse pulled out of the emergency kit or received it during the pharmacy midnight distribution. She confirmed that she did not notify the provider that the resident had an allergy to sulfamethoxazole (Bactrim DS). LPN Unit Manager AA revealed that the pharmacy receives orders through the electronic record and a faxed copy as well, then the pharmacy sends a note out to alert the facility, and a fax would come across when a medication may be contraindicated. She stated that she received education from the Director of Nursing (DON) covering medication errors with handouts. She was unsure of the reasons to bypass an alert and was unsure if the resident had received the medication before. She was later told by the DON that the resident had an allergy. She believed that the medical doctor had reviewed the chart and prescribed medication. She stated that she did not review the resident's allergies with the medical doctor. She presumed the doctor knew because that was his patient. On 10/7/2025 at 3:35, LPN Unit Manager AA returned, stating that she reviewed her notes and that she did not input the order but had received the order from the provider later that evening when she was at home and called the nurse to inform her of the order from the provider.An observation and interview with LPN CC on 10/7/2025 at 3:50 pm revealed that he found the error and contacted the Director of Nursing (DON) immediately. The Surveyor observed the computer with LPN CC and was shown the ribbon where allergies were found in the electronic medical records. LPN CC reported R4 experienced redness of the cheek and face, and was feeling hot. He stated he administered the Bactrim DS; however, he did not receive a safety alert. He revealed that when you enter a medication that a safety alert appears, and the nurse would have to notify the provider to verify that the resident needs the medication. Once the medication is overridden, the alert does not continue to appear. He reported that they treated the resident with intravenous fluids and gave her Benadryl (an antihistamine) to treat the allergic reaction. The Bactrim DS (antibiotic) was discontinued and removed from the medication cart. He did not notify the physician but did notify the DON of the allergic reaction, who obtained the orders for IV fluids and Benadryl (antihistamine).An interview with Staff Pharmacist DD on 10/7/2025 at 4:40 pm revealed that electronic records were integrated into their electronic record. Staff Pharmacist DD revealed that they receive both electronic and faxed orders from the facility. The nurses key the orders into the electronic medical record at the direction of the Physician or Nurse

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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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 0760 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility policy titled Medication Orders and Admissions revealed the facility failed to order an anticonvulsant for one of 17 sampled residents (R) (R1) who received an anticonvulsant for seizures and an antibiotic. Harm was identified to have occurred on 2/15/2025, when R1 was rehospitalized for seizure activities due to not receiving the required anticonvulsant medication. Findings included:A review of the facility policies titled Admissions, reviewed and updated in October 2016, revealed that it is the intent of the facility to gather necessary information upon a resident's admission to the facility. The procedural guidelines reflect that residents' readmission and new admission data must be recorded. A review of the policy titled Medication Orders, reviewed and updated in October 2017, revealed that medications are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe. Verbal orders are received by a licensed nurse, pharmacist, or other authorized by state law to do so . under the section of new verbal orders, the nurse will transcribe the order . verbally repeat the order back to the prescriber for verification and clarity, and then note the read back and verified on the order.A review of the electronic Medical Record (EMR) revealed that R1 was re-admitted to the facility on [DATE] from an acute care facility (hospital). R1's diagnoses included, but were not limited to, cerebral infarction due to thrombosis of the left middle cerebral artery, dysphagia following cerebral infarction, unspecified atrial fibrillation, unspecified convulsions, and a history of urinary (tract) infections.A review of the hospital Medication Reconciliation Report printed 12/19/2024 revealed a new order to start Keppra 500 milligrams (MG) tablets two times a day (BID) by mouth (PO) in addition to cephalexin 500 MG tablets every (Q) 12 hours PO for seven days.A review of the hospital Patient Summary dated 12/19/2024 revealed a discharge diagnosis of seizure and pending labs for urine culture.A review of the Physician orders for R1 revealed the new order for Keppra and cephalexin was not ordered and put into the EMR when she returned from the hospital on [DATE] through 2/15/2025 when she was sent back to the hospital for seizure activity.A review of the R1 Medication Administration Report (MAR) dated 12/19/2024 through 2/15/2025 revealed that it did not include an order for Keppra or cephalexin.A review of R1 facility Progress Notes revealed on 12/17/2024, the resident was sent to the hospital for seizure activity. On 12/19/2024, the Licensed Practical Nurse (LPN) FF documented that the resident returned to the facility at 3:00 PM. The documentation did not include verifying new orders with the physician. On 12/20/202,4 an antibiotic was ordered for a UTI (urinary tract infection). On 2/15/2025, R1 had seizure activity and was sent to the hospital.An interview with Staff Pharmacist HH on 10/8/2025 at 10:17 am revealed that electronic records were integrated into their EMR. The Staff Pharmacist HH revealed that they receive both electronic and faxed orders from the facility. The nurses key the orders into the electronic medical record at the direction of the Physician or Nurse Practitioner (NP), then the pharmacy receives the orders, and the checks and balances are put into place at that point to process an order. Orders were then sent out in the evening to the facility.An interview with the facility Pharmacy Consultant on 10/8/2025 at 10:30 am revealed that she was responsible for reviewing the orders that were in the medical records and making recommendations according to any concerns identified.An interview with LPN FF on 10/8/2025 at 10:53 am revealed that she had been at the facility for two years. She stated she received R1 from the hospital on [DATE] around 3:00 pm. She indicated she thought the orders were received earlier and had already been put into the EMR. She indicated she had received education on how to receive a resident back from the hospital.An interview with the Assistant Director of Nursing (ADON) on 10/8/2025 at 1:49 pm revealed that the facility usually received the orders from the hospital before the resident arrived. She indicated the orders are entered into the EMR by the receiving nurse, and a copy is then placed into the Unit Manager Box. She indicated she does a review of the orders within 24 hours after admission.An interview with the Director of Nursing (DON) on 10/8/2025 at 2:30 pm revealed that when a resident comes back from the hospital, any new orders are verified by the Physician and put into the EMR. It was stated by the DON that the orders are to be double-checked by the unit manager and the ADON. She stated that she expects the nurses to follow the policy on ordering medications. She indicated that R1 did not return to the facility but was admitted to another facility upon discharge from the hospital.