

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115553	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/14/2024
NAME OF PROVIDER OR SUPPLIER Magnolia Manor of Midway		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377</p> <p>Based on observations, staff interviews, record review, and a review of the facility policy titled Treatment of Residents, the facility failed to ensure privacy was provide during Activity of Daily Living (ADL) care for one of nine residents (R) (R23), the facility also failed to ensure a privacy bag was provided for one of three residents R7 that utilized a urinary catheter.</p> <p>Findings include:</p> <p>Review of the undated facility policy titled, Treatment of Residents under Intent: It is the intent of facility that all residents should be treated fairly and with kindness, respect, and dignity. Under Procedural Guidelines number (3). Residents should be examined and treated in a manner that maintains the privacy of their bodies. A closed door or drawn curtain shields the resident from passers-by. (4). Privacy of a resident body should be maintained during toileting, bathing and other activities of personal hygiene.</p> <p>1.Record review for R23 revealed the following diagnoses but not limited to atrial fibrillation, malignant neoplasm of right breast, and rheumatoid arthritis. Quarterly Minimum Data Set (MDS) assessment dated [DATE] assessed a Brief Interview for Mental Status Score (BIMS) of six indicating severe cognitive impairment. Continued review of the assessment revealed that R23 was dependent for all ADL's and always incontinent for bladder and bowel.</p> <p>During an observation on 6/11/2024 at 12:07 pm revealed certified nursing assistant (CNA), CNA AA and CNA BB providing peri care services to the resident. Continued observation of the care services being provided to R23 revealed that privacy curtains were not pulled to provide full privacy (curtains were pulled to end of the bed board and did not enclose the bed) allowing view of the resident to anyone entering the room. In addition, the window blinds were open allowing outside view of the resident.</p> <p>During an interview at the time of the observation on 6/11/2024 at 12:08 pm with Assistant Director of Nursing (ADON) and CNA BB, both staff confirmed that resident was not provided full privacy while care was being rendered. The ADON reminded CNA BB to close the window blinds and ensure privacy curtains enclosed the residents' bed.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 115553
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 6/13/2024 at 11:52 am, CNA AA confirmed that she failed to provide full visual privacy by not pulling the privacy curtains and closing the window blinds while providing peri care/incontinent care for R23.</p> <p>37650</p> <p>2. Review of the Electronic Medical Record (EMR) revealed R7 was admitted with diagnoses of but not limited to type 2 diabetes mellitus with diabetic chronic kidney disease, end stage renal disease, and chronic diastolic (congestive) heart failure.</p> <p>Review of the Physician Orders revealed an order for suprapubic catheter care every shift.</p> <p>Observation on 6/11/2024 at 1:53 pm revealed R7 suprapubic catheter in place; catheter drainage bag was hanging on the side of the bed with a large amount of urine inside; there was no dignity bag observed covering the drainage bag.</p> <p>Observation on 6/12/2024 at 3:00 pm R7 suprapubic catheter in place catheter drainage bag hanging on side of bed there was no dignity cover observed covering the drainage bag.</p> <p>Observation on 6/13/2024 at 2:33 pm revealed R7 suprapubic catheter in place with drainage bag hanging on side of bed; drainage bag was not placed in a dignity bag.</p> <p>Interview on 6/13/2024 at 2:39 pm with CNA GG revealed she cleans around R7's catheter site to ensure it does not move, and empty's the drainage bag. CNA GG revealed R7's drainage bag should have been covered and placed inside a dignity bag.</p> <p>Interview on 6/13/2024 at 2:43 pm with Licensed Practical Nurse (LPN FF) revealed R7's drainage bag should be in a privacy bag when visible to the public but may have been left on his wheelchair.</p> <p>Interview on 6/13/2024 at 3:08 pm the Unit Manager revealed R7's drainage bag should always be covered. The CNAs and Nurses are responsible for making sure the dignity bag is always in place to promote dignity of residents that are utilizing catheters.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377</p> <p>Based on observations, staff interviews, record review, review of facility documents, and review of the facility policy titled, Residents' Rights Protection, the facility failed to ensure one of nine residents (R) R18 was provided with a chair that accommodated his height and ensured body alignment. The facility also failed to ensure two of 28 residents, R16 and R51 were assessed for placement on the Secured Unit (Unit 3). The deficient practice had the potential to prevent R16, R18, and R51 from receiving care that accommodated their individual care needs.</p> <p>Findings include:</p> <p>Review of the undated facility policy titled, Residents' Rights Protection under Specific Rights: 1. Rights to Self-Determination the resident has the right: 1C.) to reside and receive services with reasonable accommodation by the facility of individual needs and preferences.</p> <p>A.Record review for R18 revealed diagnoses included but not limited to, dementia, benign prostatic hyperplasia, personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits. The Quarterly Minimum Data Set Assessment (MDS) dated [DATE] assessed a Brief Interview for Mental Status (BIMS) score of five indicating severe cognitive impairment, non-ambulatory, dependent for mobility and transfer. Resident was assessed for height of 73 inches (6 ft 1 inches) and weight of 266 lbs. (pounds).</p> <p>Observation on 6/11/2024 starting at 11:00 am to 2:07 pm, R18 was observed in the activity/common area sitting in a Geri-chair in a semi-reclining position. Ongoing observation revealed residents' upper torso and lower torso (buttock, thigh, leg) was positioned slouched and downward in the chair. Residents' arms and hands were observed hanging off the arm rest and draped down over the chair.</p> <p>Interview and observation on 6/12/2024 at 2:10 pm with the Activity Director (AD) confirmed R18 was slumped down and sliding downward in the chair during activities.</p> <p>Interview on 6/12/2024 at 2:11 pm, Certified Nursing Assistant (CNA) JJ, who served as an activity assistant, confirmed that R18 had been up in the activity area since 10 am and he was not in his regular chair.</p> <p>Interview on 6/12/2024 at 2:12 pm, CNA KK confirmed that R18 was not sitting in his assigned Geri-chair. Further interview also revealed resident was already up and dressed, by the night shift, and placed in the chair when she arrived to work today at 6:57 am.</p> <p>Interview on 6/12/2024 at 2:23 pm the Director of Nursing (DON) confirmed that R18 was not sitting in his assigned Geri-chair that was provided by Hospice. The DON also confirmed that the chair did not fit the height and body alignment for R18, and the residents Geri-chair was in the bathroom. Further interview also revealed residents chair was cleaned the night before and there was not an attempt by staff to put resident in the chair he was assigned.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 6/14/2024 at 11:13 am, R18 was observed receiving services from the Certified Occupation Therapy Assistant (COTA) the resident was noted not to be sitting upright and his body not aligned. During the observation the COTA revealed that based on her assessment of the resident, the chair provided by Hospice services did not accommodate the residents' needs and she would reach out to the nursing staff with her findings.</p> <p>B. Review of the facility document titled, Special Care Unit Criteria Review revealed a checklist used to determine placement in the Special Care Unit. The document questions included under number 1. Resident has Alzheimer's or related dementia diagnosis. 2. Resident habitually wanders or would wander out of the building and would not be able to find way back. 4. Resident is a serious danger to self or others. 5. Less restrictive alternatives have been unsuccessful. 6. Resident is able to ambulate independently.</p> <p>Review of the facility document titled, Resident Rights -Room Change revealed a section titled Room changes for medical or safety reasons: 1. A move for medical, or safety reasons will be determined by the physician, nursing staff, and the Social Service department.</p> <p>Record review for R16 revealed diagnoses including, but not limited to, schizoaffective disorder, bipolar type, mood disorder, and vascular dementia.</p> <p>Review of the Annual MDS assessment dated [DATE] and the Quarterly MDS assessment dated [DATE] documented the resident had no behaviors, was not ambulatory and was dependent on staff for Activities of Daily Living (ADL) care.</p> <p>Review of R16 's nursing progress note dated 7/4/2023 and a Facility Reported Incident dated 7/4/2023 documented that R16 would be evaluated to be taken off the Secured Unit.</p> <p>Review of a psychiatric consult dated 7/7/2023 by a Nurse Practitioner documented the resident has no wandering behaviors.</p> <p>Record review for R51 revealed diagnoses including, but not limited to Alzheimer's Disease. Further review revealed that R51 received hospice services.</p> <p>Review of the Annual MDS assessment dated [DATE] and the Quarterly MDS assessment dated [DATE] documented a BIMS score of 00 indicating severe cognitive impairment and was dependent on staff for care.</p> <p>Review of R51's care plan documented care areas of receiving hospice care and required assistance for all ADLs.</p> <p>Review of a form titled, Functional Abilities - During Stay dated 5/21/2024 documented R51 was dependent on staff for care, unable to transfer, was not ambulatory, and dependent for mobility with wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 6/12/2024 at 2:48 pm, the Assistant Director of Nursing (ADON) reported that both R16 and R51 were non-ambulatory and had not exhibited behaviors and that R16 and R51 were dependent on staff for care. She further stated that residents with behaviors should not be placed with residents who have dementia and that she was unaware that R16 was supposed to be assessed to move off the Secured Unit.</p> <p>In an interview on 6/12/2024 at 3:48 pm, the DON reported that the Secure Unit is not a memory care unit, and it was for residents who have elopement tendencies. She could not explain why R16 remained in the Secure Unit and was unaware that the resident was supposed to be assessed to be moved. She also confirmed that R51 received hospice services and resided in the Secured Unit and did not have any wandering tendencies and was non ambulatory.</p> <p>In an interview on 6/13/2024 at 4:47 pm, the Administrator and DON reported that residents are placed in the Secure Unit for safety precautions, such as elopement risks. She reported she was unaware that R51 was dependent on staff for ADL care. The DON stated that the criteria or intent for placing the resident in the unit was to keep the resident safe. The DON stated that R16 displayed no behavior problems or had exit seeking tendencies.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377</p> <p>Based on observations and staff interview, the facility failed to maintain a clean sanitary environment free of odor, replacing missing floor tiles, and ensure resident's equipment was free from rust on two of three halls.</p> <p>Finding include:</p> <p>A policy for this specific issue was requested but not provided.</p> <ol style="list-style-type: none"> 1. Observations on 6/11/2024 at 11:50 am, 6/12/2024 at 2:00 pm., and 6/13/2024 at 12:49 pm, in bathroom [ROOM NUMBER]-306 on Hall 3, a strong urine odor and missing floor tiles were noted. 2. Observation on 6/11/2024 at 12:02 pm and 6/13/2024 at 12:52 pm, in bathroom [ROOM NUMBER]-219 on Hall 2 revealed a raised toilet seat was positioned over the toilet. A closer observation revealed dark brown substances coating the frame of the raised toilet seat. 3. Observation on 6/11/2024 at 12:03 pm and 6/13/2024 at 12:23 pm, in bathroom [ROOM NUMBER]-223 on Hall 2 revealed a raised toilet seat positioned over the toilet. A closer observation revealed dark brown substances coating the frame of the raised toilet seat. <p>During a tour of the bathrooms on 6/13/2024 between 12:49 pm and 12:53 pm, with the Maintenance Director and Director of Nursing (DON), both confirmed the urine odor, missing floor tiles, and they identified the brown substance on the toilet chairs as rust. They revealed that replacing the floor tiles and the raised toilet seat would eliminate the odor in bathroom. The Maintenance Director reported being unaware of the problem and reported staff are required to submit a work order for any repairs.</p> <p>Interview on 6/13/2024 at 1:09 pm, the Housekeeping Supervisor reported being unaware of strong urine odor in room [ROOM NUMBER]-306 and stated that staff had a log to address any issues.</p>

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<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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377</p> <p>Based on staff interview ,record review, and review of the facility policy titled, Care Planning Policy, the facility failed to develop a plan of care for two of 14 residents (R) (R16 and R40). Specifically, the facility failed to create a plan of care to monitor and prevent future occurrences of abuse for R16 and failed to develop a care plan for restorative services for R40.</p> <p>Findings include:</p> <p>Review of the facility policy titled, Care Planning Policy dated October 2016 under Procedural Guidelines number 1. A comprehensive person-centered care plan shall be developed and implemented for each resident that includes measurable objectives and time frames that meet a resident 's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessments.</p> <p>Record review of R16's medical record revealed the following diagnoses but not limited to cerebral infarction, vascular dementia moderate behavior disturbances, epilepsy, intermittent explosive disorder, and schizoaffective bipolar disorder. The Quarterly Minimum Data Set (MDS) dated [DATE] assessed a Brief Interview for Mental Status score (BIMS) of 99 indicating severe cognitive impairment.</p> <p>Record review of nurse progress note dated 7/4/2023 at 2:11 pm documented that R16 had a resident-to-resident altercation with another resident on his hall. R16 was assessed and noted to have an injured upper lip.</p> <p>Review of the Facility Reported Incident (FRI) dated 7/4/2023 documented the incident and included no care plan attached. Record review for R16 revealed no care plan was developed for abuse.</p> <p>Interview on 6/12/2024 at 4:06 pm, Unit Manager LL printed out and reviewed the resident care plan and confirmed no plan of care for abuse.</p> <p>During an interview with the MDS Coordinator on 6/13/2024 at 11:21 am, the MDS Coordinator reviewed the resident 's care plan with the surveyor and confirmed that R16's record did not contain a plan of care for abuse. She reported that she was unaware that the abuse care plan needed to be done on the victim and the abuser. The Director of Nursing (DON) entered the office during the time that the MDS was looking for the record. She was informed that the abuse care plan was missing. The DON explained to the MDS Coordinator that abuse care plan should have been completed for R16.</p> <p>37650</p> <p>2.Review of the Electronic Medical Record (EMR) revealed that R40 was admitted to the facility with diagnoses of but not limited to, hemiplegia/hemiparesis following cerebral infarction affecting left non-dominant side, unspecified dementia without behavioral disturbance, personal history of Transient Ischemic Attack (TIA), and cerebral infarction without residual deficits.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Quarterly MDS dated [DATE] revealed that R40 had a BIMS score of nine (9), indicating moderate cognitive impairment. Further review of the Quarterly MDS revealed R40 required total assistance with bed mobility, transfer, bathing, dressing, and toileting. Precautions for contractures were noted on the Quarterly MDS.</p> <p>Review of the Plan of Care for R40 revealed no documentation of a plan of care for Restorative Nursing Services.</p> <p>Interview on 6/13/2024 at 3:33 pm the Restorative Care/Registered Nurse (RN) revealed she did not complete an assessment on R40 to receive Restorative Nursing Services for mobility.</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377</p> <p>Based on observations, staff interviews, record review, and review of the facility policy titled, Restorative Nursing, the facility failed to ensure three of 18 residents (R), (R18, R26, and R40) received services required to maintain or improve their functional abilities. Specifically, the facility failed to ensure R18 was provided with a Geri-chair that was properly fitted to ensure adequate body alignment, failed to provide equipment (footrest) for R26 to prevent potential for foot drop, and failed to provide Range of Motion (ROM) for left hand contracture for R40.</p> <p>Findings include:</p> <p>Review of the undated facility policy titled, Restorative Nursing revealed It is the Intent of the facility to provide nursing interventions that promote the resident's ability to attain or maintain the highest level of functioning as possible. Procedural guidelines: number 2. The facility's rehabilitative/restorative nursing care program is designed to assist each resident to maintain their highest level of functioning. Number 3. The Interdisciplinary team determines restorative need of the resident through assessment, planning, implementation, and evaluation. 4. All personnel may identify a resident with a functional decline/deficit that may be referred to Restorative Nursing.</p> <p>1. Record review for R18 revealed the following diagnoses but not limited to unspecified dementia, chronic obstructive pulmonary disease, cerebrovascular disease, and heart failure. The Annual Minimum Data Set (MDS) dated [DATE] assessed a Brief Interview for Mental Status (BIMS) score of five indicating severe cognitive impairment and extensive assistance with all Activities of Daily Living Skills (ADL) except eating.</p> <p>Observation on 6/11/2024 starting at 11:00 am to 2:07 pm, R18 was observed in the activity/common area sitting in a Geri-chair in a semi-reclining position. Ongoing observation revealed residents' upper torso and lower torso (buttock, thigh, leg) was positioned slouched and downward in the wheelchair. Residents' arms and hands were observed hanging off the arm rest and draped down over the chair.</p> <p>Interview on 6/12/2024 at 2:23 pm the Director of Nursing (DON) confirmed that R18 was not sitting in his assigned Geri-chair that was provided by Hospice. The DON also confirmed that the chair did not fit the height and body alignment for R18, and the residents Geri-chair was in the bathroom. A further interview also revealed the residents' chair was cleaned the night before and there was not an attempt by staff to put the resident in the chair he was assigned.</p> <p>2. Record review for R26 revealed the following diagnoses but not limited to intellectual disabilities. The Quarterly MDS assessment dated [DATE] assessed the resident as having severe cognitive impairment and dependent for all ADLs.</p> <p>Observation on 6/12/2024 at 10:27 am until 2:27 pm revealed R26 sitting in his wheelchair in the activity/common area. R26 was observed sitting in a wheelchair with his feet dangle in the air and not touching the floor. Further observation revealed there was not a footrest attached to the wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 6/12/2024 at 2:48 pm with Unit Nurse Supervisor Licensed Practical Nurse (LPN) MM confirmed that R26 should have had a footrest attached to his chair. She reported that R26 is at risk for edema and foot drop. She stated the certified nursing assistants (CNAs) were responsible for ensuring that the footrests are attached to the residents' wheelchairs during ADL care.</p> <p>Interview on 6/14/2024 at 11:33 am with Occupational Therapist (OT) revealed that the residents' footrest and wheelchair can be lowered to prevent the resident foot from dangling in the air. She further stated that if the resident decides to remove his foot from the footrest the wheelchair being lowered will allow the resident to rest his foot on the floor.</p> <p>37650</p> <p>3.Review of the Electronic Medical Record (EMR) revealed that R40 was admitted to the facility with diagnoses of but not limited to, hemiplegia/hemiparesis following cerebral infarction affecting left non-dominant side, unspecified dementia without behavioral disturbance, personal history of Transient Ischemic Attack (TIA), and cerebral infarction without residual deficits.</p> <p>Review of the Quarterly MDS dated [DATE] revealed that R40 had a BIMS of nine (9), indicating moderate cognitive impairment. Further review of the Quarterly MDS revealed R40 required total assistance with bed mobility, transfer, bathing, dressing, and toileting. Precautions for contractures were noted on the Quarterly MDS.</p> <p>Review of the Physician Orders showed no documentation for Restorative Services.</p> <p>Observation on 6/12/2024 at 3:06 pm revealed R40 lying in bed alert with eyes open unable to move left hand or arm; no splint noted.</p> <p>Observation on 6/13/2024 at 2:28 pm revealed R40 sitting up in bed talking with roommate using one hand (right) to pull the covers back and attempt to move the bedside table; R40 was unable to move his left hand or arm to pull the covers back.</p> <p>Interview on 6/13/2024 at 3:24 pm the Director of Nursing (DON) revealed R40 was not receiving Restorative Care Services secondary to being on hospice care. The DON revealed a consultation for Restorative Care Services had not been completed.</p> <p>Interview on 6/13/2024 at 3:33 pm the Restorative Care Nurse/RN revealed she did not complete an assessment on R40 to receive Restorative Care Services for mobility or range of motion. The RN revealed that she was told if a resident was on hospice services they did not get restorative services, but later found that to be untrue.</p> <p>Interview on 6/13/2024 at 3:33 pm the Restorative Care Nurse/RN revealed she did not complete an assessment on R40 to receive Restorative Care Services for mobility or range of motion. The RN revealed that she was told if a resident was on hospice services they did not get restorative services, but later found that to be untrue.</p>		

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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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377</p> <p>Based on observation, and staff interviews, the facility failed to ensure personal care items were safely stored in one of eleven (11) shared bathrooms of rooms [ROOM NUMBERS] on the 300 Hall. Specifically, the facility failed to ensure personal shaving cream was not stored in room [ROOM NUMBER] shared bathroom allowing unauthorized access that could have potentially been ingested by other residents on the unit.</p> <p>Findings include:</p> <p>Review of the personal shave cream pamphlet listed warnings concerning the ingredients. The warnings stated personal shave cream contain gas under pressure, may explode if heated, protect from sunlight, Store in a well-ventilated place. Inhalation: move to fresh air: Seek medical advice if cough, shortness of breath or other respiratory problems occur, Use only as directed. Ingestion: rinse mouth immediately. Call a physician or Poison Control Center immediately. May cause Nausea or vomiting. Eyes: Rinse immediately with plenty of water, also under the eyelids, for at least 15 minutes. Obtain medical attention if irritation persists. Accident release measures: avoid breathing vapor.</p> <p>Observation on 6/11/2024 at 12:13 pm of shared bathroom in room [ROOM NUMBER] revealed a can of personal shave cream positioned on the bathroom sink within view.</p> <p>Observation on 6/12/2024 at 2:34 pm, with the Assistant Director of Nursing (ADON) confirmed the shaving cream in the bathroom. She reported that based on the ingredients in the shaving cream, the product is hazardous if ingested and the creme should not be allowed in the room.</p> <p>Interview on 6/13/2024 at 12:02 pm with Licensed Practical Nurse (LPN) PP confirmed the shaving cream in the room. She reported that the risk is extremely high for accidental ingestion due to the wandering residents on the unit were assessed to have low cognition and a lack of safety awareness.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37650</p> <p>Based on observations and staff interviews, the facility failed to properly label opened food items in the walk-in refrigerator and walk-in freezer, discard expired foods in the walk-in refrigerator, clean the ice machine, and ensure that kitchen staff wore beard guards while in the food preparation area. These deficient practices had the potential to adversely affect the 72 residents receiving an oral diet.</p> <p>Findings include:</p> <p>During a tour of the kitchen on [DATE] from 11:00 am to 12:00 pm, observation of the ice machine, located next to the handwashing station, revealed dust and dirt around the inside of the ice machine in the top corners and the bottom interior of the lid.</p> <p>Observation of the walk-in cooler on [DATE] at 11:09 am revealed two bags of romaine salad mix and one bag of [NAME] slaw mix with a use-by date of [DATE]. Continued observation of the walk-in cooler revealed three half-stacks of cheese not in the original packaging and undated and unlabeled, and one undated and unlabeled open box of liquid eggs.</p> <p>Observation of the walk-in freezer on [DATE] at 11:18 am revealed three packs of waffles removed from the original package which were unlabeled and undated, and two packs of pancakes not in the original packaging unlabeled and undated.</p> <p>Observation on [DATE] from 11:00 am to 12:00 pm, during the tour of the kitchen, revealed Dietary Cooks CC and EE were not wearing beard guards while in the kitchen.</p> <p>In an interview on [DATE] at 11:30 am, Dietary [NAME] CC stated he was the acting Dietary Manager. Dietary [NAME] CC revealed the ice machine was cleaned weekly by the kitchen aides and the last cleaning was completed on [DATE]. During further interview, Dietary [NAME] CC revealed food items should be labeled and dated when opened and removed from the original packaging, and expired foods should be discarded. He confirmed staff with beards should always wear beard guards while in the kitchen.</p> <p>An interview on [DATE] at 2:18 pm with the Administrator revealed her expectation was for the male dietary aides with facial hair to always wear a beard guard while in the kitchen. The Administrator revealed she expected the dietary staff to label and date food items out of the original package and opened food items, and the scheduled cleaning for the ice machine should be followed.</p>		

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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>Provide and implement an infection prevention and control program.</p> <p>36377</p> <p>Based on observations, staff interviews, record review, and review of the facility policy titled Consideration for Use of Enhanced Barrier Precautions in Skilled Nursing Facilities, the facility failed to ensure staff used appropriate Personal Protective Equipment (PPE) for one of five residents (R) (R23) reviewed for Enhanced Barrier Precautions. This deficient practice had the potential to place R23 and other residents at risk for avoidable infections.</p> <p>Findings include:</p> <p>A review of the facility policy titled, Consideration for Use of Enhanced Barrier Precautions in Skilled Nursing Facilities, dated June 2021, under Executive Summary number 2. Enhanced Barrier Precautions (EBP) is an approach of target gown and glove use during high-contact resident care activities, designed to reduce transmission of S. aureus and MDRO (multidrug -resistant organism). 3. EBP may be applied when contact precautions do not otherwise apply to residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status. Infection or colonization with an MDRO. 4. Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE with hand hygiene products at the point of care.</p> <p>Record review of R23 's medical record revealed the following diagnoses, but not limited to, malignant neoplasm of unspecified site of right female breast (wound).</p> <p>Record review of the Physician Order Form, dated June 2024, documented an order for Enhanced Barrier Precautions related to a wound.</p> <p>Observation on 6/11/2024 at 12:07 pm revealed Certified Nursing Assistants (CNA) KK and CNA BB providing incontinent care to R23. Continued observation revealed that CNA BB did not wear PPE while providing incontinent care. Further observation revealed there was no PPE readily available for staff use in the hallway or inside R23's room, nor a container for discarding PPE. Observation revealed there was Enhanced Barrier Precautions signage on R23's door. The sign did not provide private specific instructions about donning and doffing (putting on and removing) PPE.</p> <p>Observation on 6/11/2024 at 12:07 pm, revealed the Assistant Director of Nursing (ADON) provided instruction to the CNAs about providing privacy during care by using privacy curtains but did not mention the failure to wear PPE during high-contact resident care.</p> <p>In an interview on 6/13/2024 at 3:30 pm, the ADON stated that her focus was on the CNAs not pulling the privacy curtains and not the PPE. She reported that PPE is kept at the nurse station for CNAs to use during patient care. She confirmed that CNA KK and CNA BB did not wear PPE during high-contact resident care.</p> <p>In an interview on 6/14/2024 at 9:20 am, the Administrator reported being unaware of the issues regarding staff not wearing PPE while providing high-contact resident care. She reported that her expectations were that staff should wear PPE and that in-services would be provided to staff.</p> <p>(continued on next page)</p>		

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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>In an interview with the Infection Control Preventionist (IPC) on 6/14/2024 at 11:00 am, she reported that her expectation is that staff wears PPE while providing high-contact resident care. She confirmed providing in-service to staff about PPE use. She stated that PPE was kept at the front desk and not at the resident rooms. She reported that her plans were to make changes and provide more specific instructions about PPE use. The IPC placed a second EBP sign on R23's door with instructions on donning and doffing PPE.</p> <p>In an interview on 6/14/2024 at 11:35 am, CNA BB confirmed not wearing PPE while providing incontinent care to R23. She reported that she just forgot to wear PPE and was more focused on resident care.</p>		