STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115599	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Manor of Marion County	349 Geneva Road Buena Vista, GA 31803

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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 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** Based on observation, interview, and record review, the facility failed to develop and/or implement a comprehensive care plan related to fall prevention and contracture management for two residents (R) (R9 and R16) from a sample of 29 residents. The deficient practice had the potential to prevent residents from reaching their highest practicable level of functioning and compromise resident safety. Findings include:1. Review of R9's Face Sheet located in the electronic medical record (EMR) under the Face Sheet tab revealed R9 was admitted to the facility on [DATE] with diagnoses of but not limited to dementia with agitation, diabetes, and peripheral vascular disease.Review of R9's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/05/25 and located under the RAI [Resident Assessment Instrument] tab of the EMR revealed a Brief Interview for Mental Status (BIMS) score of seven out of 15 which indicated moderate cognitive impairment. Review of R9's Care Plan dated 07/19/2025 revealed, [R9] has history of falling, prior to admission R/T [related to] low b/p [blood pressure]. She continues to be at risk for falls, no safety awareness, impaired mobility, impaired cognition. The approaches included, Replace non-skid socks in room with slip grip socks [and] provide proper, well-maintained footwear. Review of R9's Event Reports provided on paper by the Administrator revealed the following falls, without any injuries, over the past six months:1. On 07/16/2025, R9 fell in her room and had regular socks on. The intervention was, Replace regular socks with non-slip socks.2. On 07/19/2025, R9 fell in her room and had bare feet. Her non-slip socks were in her hand. The intervention was provide assistance to the bathroom at 5:00 AM. 3. On 07/29/2025, R9 fell in her room and had bare feet. The intervention was to apply non-skid strips to the floor next to her bed.4. On 11/18/2025, R9 fell in her room. She did not have non-slip socks on and the grip strips on the floor had decreased grip. The intervention was to replace the non-skid tape on the floor.5. On 01/21/2026, R9 fell in her room when she attempted to walk independently and her feet got tangled. No new interventions had yet been implemented as the investigation was still open. During an observation and interview on 01/27/2026 at 11:38 AM in R9's room, R9 was seated in her wheelchair behind the curtain, not visible from the doorway. She had regular socks on without non-slip strips. She stated she had just taken a shower, and the staff had put the socks on her. R9 was not wearing shoes. R9 stated she needed non-slip socks, so she did not fall. During an observation and interview on 01/27/2026 at 2:19 PM in R9's room, R9 was again seated in her wheelchair behind the curtain. She had regular socks on without non-slip strips and was not wearing shoes. R9 confirmed she was not wearing non-slip socks.During an observation and interview on 01/28/2026 at 8:50 AM in R9's room, R9 was lying in bed behind the curtain. She was wearing regular socks without non-slip strips. R9 confirmed she was not wearing non-slip socks and stated she would like them to be changed to the socks with the non-slip strips to prevent her from falling. During an interview on 01/28/2026 at 3:36 PM, Certified Nurse Aide (CNA) 3 stated R9's fall prevention measures included proper footwear and/or non-slip socks. During a concurrent observation in R9's room, CNA3 confirmed R9 was not wearing socks with non-slip grips and she should be. CNA3 found a pair of non-slip socks in R9's dresser and changed her socks. CNA3 stated the non-slip socks (continued on next page)

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	should be on whenever the resident was in bed and the resident should have shoes on when up in her wheelchair. During an interview on 01/29/2026 at 11:10 AM, CNA2 stated R9 was impulsive and had a tendency to get up independently no matter how many times she was reminded to call for help. CNA2 stated R9 should be wearing shoes while up in her wheelchair and should have non-slip socks on all other times. During an interview on 01/29/2026 at 1:42 PM, Unit Manager (UM) 2 stated R9's fall prevention measures included the use of non-slip socks in addition to the non-skid strips on the floor. UM2 confirmed the floor strips did not have much grip to them.Review of the facility's policy titled, Fall Management dated September 2014 documented, Resident's at high risk will be placed on a fall management program and appropriate interventions put into place as indicated by assessment. 2. Review of R16's Face Sheet located in the electronic medical records (EMR) under the Resident tab indicated an admission date of 12/14/2022, with diagnoses of but not limited to chronic kidney disease and type 2 diabetes.Review of R16's annual Minimum Data Set (MDS) located in the EMR under the RAI tab with an Assessment Reference Date (ARD) of 12/05/2025 indicated a Brief Interview for Mental Status (BIMS) score of two which indicated severe cognitive impairment.Review of R16's annual Care Area Assessment (CAA) located in the EMR under the RAI tab with an assessment date of 11/19/2025, documented the resident was at risk for functional decline because of contractures.Review of R16's Care Plan located in the EMR under the RAI tab revealed no mention of R16's right hand contracture.During an interview and observation on 01/26/2026 at 3:10 PM, R16 had her index through her little finger, on her right hand, in a contracted position, with her four fingers bent and her fingernails touching her palm. She stated she could not open any finger and wished she could open them. During an interview on 01/28/2026 8:50 AM, R16 stated she could not use any of the finger on her right hand, they are just stuck like that, so I do what I can. During an interview on 01/28/2026 at 9:43 AM, with Certified Nurse Aide (CNA) 2 who stated she remembered when R16 had a splint for her right hand. She stated she had not seen one in the last two years. CNA2 stated they are not currently doing anything for R16's contracture. During an interview on 01/28/2026 at 9:49 AM, with the Restorative Aide (RA) confirmed she remembered R16 used to have a splint but did not any longer. The RA stated currently they are not doing anything with her right hand. During an interview 01/28/2026 at 9:53 AM, the Director of Rehab (DOR) stated they would only screen a resident if there was a referral from nursing. She stated that she remembered when R16 had a splint, but she would decline wearing it. The DOR confirmed R16 had not received therapy services since that time. During an interview on 01/28/2026 at 9:58 AM, the Director of Nursing (DON) and the Assistant Director of Nursing (DON) stated that the contracture was documented on the quarterly nursing assessment. The DON stated the contracture should also be on the care plan and include interventions that indicated the contracture should be reassessed quarterly for pain and cleanliness as well as determine if the splint should be reconsidered based on R16's compliance. During an interview on 01/28/2026 at 10:30 AM, with the MDS Coordinator (MDSC) who stated with a contracture she would determine if the resident had splints or had refused. She stated that the contracture and the interventions should be on the care plan and confirmed currently there was nothing. She stated it was important to monitor the contracture to ensure it was not getting worse. The MDSC confirmed there was currently nothing in place to assess the contracture.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and document review, the facility failed to ensure medications were held according to parameters ordered by the physician for one of five residents (R) (R9) reviewed for unnecessary medications. The deficient practice increased the potential risk of adverse clinical outcomes.Findings include:Review of R9's Face Sheet located in the electronic medical record (EMR) under the Face Sheet tab revealed admitted to the facility on [DATE] with diagnoses including but not limited to essential primary hypertension, dementia with agitation, diabetes, and peripheral vascular disease.Review of R9's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/05/2025 and located under the RAI [Resident Assessment Instrument] tab of the EMR revealed a Brief Interview for Mental Status (BIMS) score of seven out of 15 which indicated moderate cognitive impairment. Review of R9's Orders tab of the EMR revealed a physician's order dated 07/11/2025, for carvedilol (medication to lower blood pressure), 12.5 milligrams (mg) twice daily. The order documented, Hold for pulse less than 70 or SBP [systolic blood pressure] less than 120. Review of R9's Medication Administration Record (MAR) dated 12/01/2025 through 01/26/2026 and located under the Reports tab of the EMR revealed 25 doses of carvedilol were not documented as held when indicated by the physician-ordered parameters.1. On 12/03/2025, the PM dose was given with a SBP of 109 and pulse of 59.2. On 12/04/2025, the PM dose was given with a pulse of 54.3. On 12/05/2025, the AM dose was given with a SBP of 98 and pulse of 55.4. On 12/07/2025, the AM dose was given with a SBP of 109 and pulse of 64.5. On 12/08/2025, the AM dose was given with a SBP of 110 and pulse of 56.6. On 12/08/2025, the PM dose given with a pulse of 64.7. On 12/09/2025, the AM dose was given with a pulse of 60.8. On 12/09/2025, the PM dose was given with a pulse of 66.9. On 12/12/2025, the PM dose was given with a pulse of 61.10. On 12/13/2025, the AM dose was given with a SBP of 111 and pulse of 60.11. On 12/14/2025, the AM dose was given with a SBP of 106 and pulse of 60.12. On 12/16/2025, the AM dose was given with a pulse of 65.13. On 12/17/2025, the PM dose was given with a pulse of 68.14. On 12/20/2025, the PM dose was given with a pulse of 57.15. On 12/25/2025, the PM dose was given with a SBP of 118 and pulse of 58.16. On 12/26/2025, the AM dose was given with a SBP of 116 and a pulse of 66.17. On 12/26/2025, the PM dose was given with a SBP of 116.18. On 12/27/2025, the PM dose was given with a pulse of 64.19. On 12/28/2025, the PM dose was given with a SBP of 118.20. On 01/02/2026, the AM dose was given with a pulse of 50.21. On 01/03/2026, the PM dose was given with a SBP of 118 and pulse of 69.22. On 01/05/2026, the PM dose was given with a pulse of 66.23. On 01/12/2026, the AM dose was given with a pulse of 48.24. On 01/13/2026, the PM dose was given with a pulse of 65.25. On 01/17/2026, the PM dose was given with a pulse of 66.During an interview on 01/29/2026 at 1:52 PM, Unit Manger (UM) 2 stated this was a problem with the way the nurse input documentation on the MAR. UM2 stated even though if a nurse documented a medication was held, if the All Prepped and Given button was pressed rather than the Complete button, the MAR would not show the medication was held. UM2 stated she had reported this issue to the Director of Nursing (DON) but had not done any formal training with the nursing staff.During an interview on 01/29/2026 at 3:40 PM, the Director of Nursing (DON) stated she noticed the problem with medications appearing as if they were not held according to the ordered parameters and had discovered it was an issue with the nursing staff clicking the wrong button at the completion of medication administration. The DON stated the issue was followed by the facility's quality improvement committee from February 2025 to July 2025. She stated education was done with the staff along with MAR audits during that time. The DON stated she did not continue regular MAR audits but continued random checks, so in December 2025 she observed the same problem re-occurring. The DON stated she provided staff training on 12/19/2025, however there were no additional quality improvement activities to ensure compliance.Review of the facility's 12/29/2025 in-service record provided on paper by the DON revealed, It has been brought to our (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	attention that medications are being signed in error due to a glitch in [the EMR]. Please ensure you are signing out refused medications first (separately from your prepped' medications). If meds are 'prepped' and 'not given' and you select 'all prepped given,' [the EMR] will sign all meds as administered, including those selected as 'not given.' Please ensure we are taking our time and being observant to ensure accurate documentation.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, record review, and interviews, the facility failed to ensure one resident (R) (R16) from a sample of 29 residents received appropriate services for a contracture. This deficient practice had the potential for worsening contracture of the right hand and prevent maximum practicable level of function.Findings include:Review of R16's Face Sheet located in the electronic medical records (EMR) under the Resident tab indicated an admission date of 12/14/2022, with diagnoses of but not limited to chronic kidney disease and type 2 diabetes.Review of R16's annual Minimum Data Set (MDS) located in the EMR under the RAI tab with an Assessment Reference Date (ARD) of 12/05/2025 indicated a Brief Interview for Mental Status (BIMS) score of two which indicated severe cognitive impairment.Review of R16's annual Care Area Assessment (CAA) located in the EMR under the RAI tab with an assessment date of 11/19/2025, documented the resident was at risk for functional decline because of contractures.Review of R16's Care Plan located in the EMR under the RAI tab revealed no mention of R16's right hand contracture.During an interview and observation on 01/26/2026 at 3:10 PM, R16 had her index through her little finger, on her right hand, in a contracted position, with her four fingers bent and her fingernails touching her palm. She stated she could not open any finger and wished she could open them. During an interview on 01/28/2026 8:50 AM, R16 stated she could not use any of the finger on her right hand, they are just stuck like that, so I do what I can. During an interview on 01/28/2026 at 9:43 AM, with Certified Nurse Aide (CNA) 2 who stated she remembered when R16 had a splint for her right hand. She stated she had not seen one in the last two years. CNA2 stated they are not currently doing anything for R16's contracture. During an interview on 01/28/2026 at 9:49 AM, with the Restorative Aide (RA) confirmed she remembered R16 used to have a splint but did not any longer. The RA stated currently they are not doing anything with her right hand. During an interview 01/28/2026 at 9:53 AM, the Director of Rehab (DOR) stated they would only screen a resident if there was a referral from nursing. She stated that she remembered when R16 had a splint, but she would decline wearing it. The DOR confirmed R16 had not received therapy services since that time. During an interview on 01/28/2026 at 9:58 AM, the Director of Nursing (DON) and the Assistant Director of Nursing (DON) stated that the contracture was documented on the quarterly nursing assessment. The DON stated the contracture should also be on the care plan and include interventions that indicated the contracture should be reassessed quarterly for pain and cleanliness as well as determine if the splint should be reconsidered based on R16's compliance. During an interview on 01/28/2026 at 10:30 AM, with the MDS Coordinator (MDSC) who stated with a contracture she would determine if the resident had splints or had refused. She stated that the contracture and the interventions should be on the care plan and confirmed currently there was nothing. She stated it was important to monitor the contracture to ensure it was not getting worse. The MDSC confirmed there was currently nothing in place to assess the contracture.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure identified fall prevention interventions were implemented for one of three residents (R) (R9) reviewed for falls. The deficient practice increased the risk of falls for R9.Findings include:Review of R9's Face Sheet located in the electronic medical record (EMR) under the Face Sheet tab revealed R9 was admitted to the facility on [DATE] with diagnoses of but not limited to dementia with agitation, diabetes, and peripheral vascular disease.Review of R9's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/05/25 and located under the RAI [Resident Assessment Instrument] tab of the EMR revealed a Brief Interview for Mental Status (BIMS) score of seven out of 15 which indicated moderate cognitive impairment.Review of R9's Care Plan dated 07/19/2025 revealed, [R9] has history of falling, prior to admission R/T [related to] low b/p [blood pressure]. She continues to be at risk for falls, no safety awareness, impaired mobility, impaired cognition. The approaches included, Replace non-skid socks in room with slip grip socks [and] provide proper, well-maintained footwear. Review of R9's Event Reports provided on paper by the Administrator revealed the following falls, without any injuries, over the past six months:1. On 07/16/2025, R9 fell in her room and had regular socks on. The intervention was, Replace regular socks with non-slip socks.2. On 07/19/2025, R9 fell in her room and had bare feet. Her non-slip socks were in her hand. The intervention was to provide assistance to the bathroom at 5:00 AM. 3. On 07/29/2025, R9 fell in her room and had bare feet. The intervention was to apply non-skid strips to the floor next to her bed.4. On 11/18/2025, R9 fell in her room. She did not have non-slip socks on and the grip strips on the floor had decreased grip. The intervention was to replace the non-skid tape on the floor.5. On 01/21/2026, R9 fell in her room when she attempted to walk independently and her feet got tangled. No new interventions had yet been implemented as the investigation was still open. During an observation and interview on 01/27/2026 at 11:38 AM in R9's room, R9 was seated in her wheelchair behind the curtain, not visible from the doorway. She had regular socks on without non-slip strips. She stated she had just taken a shower, and the staff had put the socks on her. R9 was not wearing shoes. R9 stated she needed non-slip socks, so she did not fall. During an observation and interview on 01/27/2026 at 2:19 PM in R9's room, R9 was again seated in her wheelchair behind the curtain. She had regular socks on without non-slip strips and was not wearing shoes. R9 confirmed she was not wearing non-slip socks.During an observation and interview on 01/28/2026 at 8:50 AM in R9's room, R9 was lying in bed behind the curtain. She was wearing regular socks without non-slip strips. R9 confirmed she was not wearing non-slip socks and stated she would like them to be changed to the socks with the non-slip strips to prevent her from falling. During an interview on 01/28/2026 at 3:36 PM, Certified Nurse Aide (CNA) 3 stated R9'sfall prevention measures included proper footwear and/or non-slip socks. During a concurrent observation in R9's room, CNA3 confirmed R9 was not wearing socks with non-slip grips and she should be. CNA3 found a pair of non-slip socks in R9's dresser and changed her socks. CNA3 stated the non-slip socks should be on whenever the resident was in bed and the resident should have shoes on when up in her wheelchair. During an interview on 01/29/2026 at 11:10 AM, CNA2 stated R9 was impulsive and had a tendency to get up independently no matter how many times she was reminded to call for help. CNA2 stated R9 should be wearing shoes while up in her wheelchair and should have non-slip socks on all other times. During an interview on 01/29/2026 at 1:42 PM, Unit Manager (UM) 2 stated R9's fall prevention measures included the use of non-slip socks in addition to the non-skid strips on the floor. UM2 confirmed the floor strips did not have much grip on them.Review of the facility's policy titled, Fall Management dated September 2014 documented, Resident's at high risk will be placed on a fall management program and appropriate interventions put into place as indicated by assessment.