STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425032	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Manor - Inman	63 Blackstock Road Inman, SC 29349

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42424 Based on interview, record review, and review of facility policy, the facility failed to ensure that Resident (R)2 was free from physical abuse by Licensed Practical Nurse (LPN)2, for 1 of 19 residents reviewed for abuse. Findings include: Review of the facility policy titled Leadership Policies and Procedures Organizational Ethics Abuse, Neglect, Exploitation, or Mistreatment last revised on 10/23/19, documented, the facility's leadership prohibits neglect, mental, physical, and or verbal abuse, use of a physical of chemical restraint not required to treat medical condition, involuntary seclusion, corporal punishment and misappropriation of a patient/resident property and/or funds and ensures violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or mental anguish. Abuse also includes the deprivation by an individual, including caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. Willful as used in the individual means the individual must have acted deliberately, not that individual must have intended to inflict injury or harm. Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Review of R2's Face Sheet revealed R2 was admitted to the facility on [DATE], with diagnoses including but not limited to: dementia with moderate anxiety, major depressive disorder, generalized anxiety disorder and, dysphasia. Review of R2's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 11/01/24, revealed R2 had a Brief Interview for Mental Status (BIMS) score of 99, which indicates that R2 was not cognitively intact and was unable to complete the 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 0600 Level of Harm - Actual harm Residents Affected - Few	Review of a Witness Statement written by LPN1, dated 10/31/24, documented, I [LPN2] was sitting at the nurses station on Unit 1 at 6:35 AM. The resident (R2) came up to the nurses station asking the third shift nurse (LPN2) for a 'puff' of her inhaler several times. [LPN2] kept ignoring [R2] at first but later began to argue with the resident about the inhaler. [R2] became upset and said that she was going to call 911. The resident then proceeded to walk around to the phone and lifted it up and started dialing the number. [LPN2] then tried to snatch the telephone from the resident, and they began tussling with the phone. I asked [LPN2] to let the resident have the phone, once [LPN2] let go of the telephone the resident reared back with the phone and hit [LPN2] hard in the face with the telephone. [LPN2] then snatched the telephone back from the resident and hit her gently in the face. [LPN2] then went around the nurses stations towards the resident and the resident turned and walked towards me [LPN1]. I then stepped between both of them, the resident winked at this nurse [LPN1], then closed her eyes and slid to the floor. After assisting the resident back up, this nurse escorted the resident back to her room and called to notify the Director of Nursing (DON). Review of a Witness Statement written by LPN2, dated 10/31/24, documented, At 6:45 AM the resident came up to the nurses station for an inhaler. I let the resident [R2] know that she did not have an inhaler until later in the day. Resident then went around to the phone and picked up the phone and I touched the cord. When I did, [R2] hit me hard in the face. She then went around to [LPN1] and when I walked to her she said oh and fell in my arms. I placed the resident on the floor for a few minutes and then [LPN1] ambulated her back to her room. Review of a Conclusion Summary dated 10/31/24, documented, At 6:45 AM [LPN1] employed by the facility witnessed [LPN2], an agency LPN strike a resident in the face with a telephone. The altercation occurred because the resident had asked to be given an inhaler, which was prescribed for her to given PRN (as needed). The nurse responded to the resident, you don't have one and the resident proceeded to pick up the phone to call 911. [R2] and [LPN2] tussled with the phone and the nurse was able to grab the phone from the resident. Resident then walked away from the desk and proceeded to use another phone on the hall and [LPN2] attempted to take that phone away from [R2] as well. Aggravated, [R2] hit [LPN2] in the face with the phone and [LPN2] hit the resident back in the face with the phone. Eyewitness who was present immediately called the DON to report this incident and escorted the resident to her room and remained with her until the other nurse had left the unit as that nurse had instructed her to do. After administrative investigation concluded it revealed that the allegation of physical abuse is substantiated. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/19/24 at 3:10 PM, LPN1 revealed that they witnessed LPN2 hit R2 while at the nurses station on Unit 1. R2 came to the nurses station to ask for her PRN (as needed) inhaler and requested her nurse for the day, R2 requested the inhaler from LPN2 several times. LPN2 refused to give R2 her inhaler and stated that she did not have a Physician Order for an inhaler but made no attempts to look at R2's medical record or in the medication/treatment carts. LPN2 and R2 began to argue with each other, then R2 attempted to call 911 with the phone at the nurses station. LPN2 refused to allow R2 to use the phone and the two started tugging back and forth with the phone then I (LPN1) intervened by trying to deescalate the situation by telling LPN2 to let go of the phone. LPN1 stated eventually LPN2 let go of the phone and R2 hit LPN2 hard in the face with the phone, LPN2 retaliated and hit R2 back in the face with phone (but not as hard). LPN1 further stated, she got between the resident and LPN2 to stop them from fighting anymore. R2 then slid herself to the ground (purposely), I had to find someone to help me assist the resident up from the floor. After finding help with assisting the resident back into her wheelchair, I assisted the resident to her room and instructed her to stay there for a while because I didn't want R2 and LPN2 to cross paths again. I then went outside to notify the Director of Nursing (DON) of the situation. LPN1 further stated, R2 did not have any injuries due to the incident and LPN2 was not allowed to return back to the facility as an agency nurse. LPN1 stated that LPN2 previously worked at the facility as a staff nurse but was eventually terminated due to behavioral issues/customer service. LPN1 stated that LPN2 often had anger issues but mostly with tone/verbally. LPN1 stated that she never witnessed LPN2 be physically abusive to a resident in the past but has overheard LPN2 be rude to residents/other staff members. An attempted interview on 11/19/24 at 3:50 PM, with R2 was unsuccessful due to her cognitive status, a phone call was made to her Resident Representative and a message was left with contact information. An attempted interview with LPN2 on 11/20/24 at 11:06 AM, was unsuccessful, a voicemail message was left with callback information. During a phone interview on 11/20/24 at 12:12 PM, with the Agency Staffing Coordinator revealed that they were not allowed to disclose any information at this time related to LPN2's employment status. The Agency Staffing Coordinator stated that the Administrator of Staffing Agency will call back when they return in the office and provided call back information. A call back was never received from the Agency Staffing company. A second attempt on 11/20/24 at 12:30 PM, was made to LPN2 but was unsuccessful. A third attempt on 11/20/24 at 12:46 PM, LPN2 stated that they are not at liberty to speak with the state agency related to this matter at this time and provided information to their lawyer. During an interview on 11/20/24 at 4:48 PM, the Assistant Director of Nursing (DON) revealed that the abuse allegation was substantiated and LPN2 was put on a do not return list. The DON stated they were notified around 7 that morning that LPN1 witnessed LPN2 hit R2. When they arrived to the facility, R2 was in her room and they assessed the resident and found no injury. LPN2 was at the nurses station completing medication count with another nurse so they could exit the facility. I notified the resident representative along with the medical director and law enforcement. Law enforcement was able to interview the resident and LPN1 and both confirmed that LPN2 hit R2 with a phone. The last updates that I have for the incident was that law enforcement was pursing LPN2, and she should have a court date soon.