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	12/19/2024

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51857 Based on observations, interviews, record review and review of facility policy, the facility failed to ensure that medications belonging to Resident (R)15 were properly stored, secured, and/or administered prior to staff leaving the room for 1 of 2 residents reviewed. Findings include: Review of the facility policy titled, Pharmacy Services, Policies and Procedures- Section 8: Medication Storage, with a revision date of 04/17/24, documented, 1. Medications and biologicals are stored safely, securely and properly following the manufacturer's recommendations or those of the supplier. In accordance with State and Federal laws, the facility will store all drugs and biologicals in locked compartments under proper temperatures and other appropriate environmental controls to preserve their integrity. 2. The medication and biological supply are only accessible to licensed nursing personnel, pharmacy personnel or authorized staff members. Review of the facility policy titled, Nursing Policies and Procedures- Medication Management Program with a revision date of 05/05/23, documented, 7. Medications are administered no more than one hour before to one hour after the designated medication pass time. 10. The authorized staff member or licensed nurse must remain with the resident while the medication is swallowed. Never leave medication in a resident room without order to do so. Review of R15's Face Sheet revealed he was admitted to the facility on [DATE], with diagnoses including, but not limited to: respiratory failure, lymphedema, chronic venous hypertension of right lower extremity, and cirrhosis of liver. Review of R15's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/01/24 revealed R15 had a Brief Interview of Mental Status (BIMS) score of 15 of 15, indicating that the resident was cognitively intact. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425032	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Magnolia Manor - Inman		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R15's Medication Administration Record (MAR) for December 2024, Physician Orders dated 12/18/24, revealed an administration record for 9:00 AM of Budesonide -formoterol HFA aerosol inhaler; 160/4.5, Coreg 6.25 mg tab, Multi Vite 400-50-500mg capsule, Ferrous Sulfate 325mg tab, Furosemide 40 mg tab, Lactulose solution 10gr/15ml syrup, Lidocaine Adhesive Patch 4%, Mucinex 600mg tab, Protonix 40mg capsule, Potassium Chloride 20 mg capsule, Prostat 30ml syrup, Spironolactone 25mg tab, Ventolin HFA inhaler 90mcg, and Rifaximin 550mg tab. Further review of the MAR revealed Licensed Practical Nurse (LPN)3 signed off for administration on 12/18/24, as a late entry for medications at 10:30 AM. Review of R15's Physician Orders did not include an order for self-administration of medication. During an observation on 12/18/24 at 11:00 AM, during the initial tour of R15's room, revealed, two clear medicine cups at the right side of bed on the overbed table. One cup contained multiple-colored pills. The other cup contained a light brown liquid. Both cups were not labeled as to the contents. There were also medications that were in boxes and packages on the overbed table. During an interview on 12/18/24 at 11:23 AM, Certified Nursing Assistant (CNA)1 revealed that she was aware of the medications on the overbed table for R15. CNA1 stated she noticed the pills at 11:15 AM. CNA1 stated she left the pills there and went to the nurse's station to notify Licensed Practical Nurse (LPN)3, but LPN3 was at lunch. CNA1 further stated she didn't address this issue with anyone else; therefore, the medication remained on the overbed table at bedside as she exited the room. During an interview on 12/18/24 at 11:29 AM, LPN2 verified the medications on the overbed table in R15's room, LPN2 confirmed the finding of one empty medicine cup, and the other medicine cup with the light brown liquid inside, along with a Lidocaine Patch 700mg, Fluticasone nasal spray and Budesonide 160/4. 5mg inhaler. LPN2 stated R15 was not his resident and he had not been in the room today. LPN2 confirmed that LPN3 was the nurse caring for R15, but she was on lunch. During an interview on 12/18/24 at 1:57 PM, LPN3 confirmed she was the nurse caring for R15. LPN3 stated his BIMS is 15, and he told her to leave the medicine, and she thought he would take it right then. LPN3 stated her normal procedure includes looking at the medication list, checking the medication dosage, pulling medication from the packages, knocking on the door and telling the residents she's coming in to give them their medication. She has the resident's medication ready when she walks in. LPN3 stated that everything she takes in the room with her, she brings back out after usage. LPN3 further stated she was going to double back to R15's room but got sidetracked. LPN3 states R15 always takes his medicine, and most of the time he comes to the cart and takes his medicine. LPN3 stated, I know I shouldn't have left the medications by his bed, but I felt he would have taken his medicine. LPN3 concludes that she understands that medication can not be left at bedside because someone else could have gotten it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425032	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Magnolia Manor - Inman		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/19/24 at 9:38 AM, the Interim Director of Nursing (DON) stated that during medication administration she has the MAR in front of her to check the five routes of medication administration. Also, identifying the patient and staying there as long as it takes to ensure the resident takes all medication. The DON revealed the expectation for staff is to follow policy that medication should be administered at bedside and watched. The DON stated she wants to ensure the resident doesn't choke or pocket the medication. She also wants to ensure wanderers don't take the medication. The timeframe for medicine administration is one hour before and one hour after the prescribed order time. The facility does keep some over-the-counter medications at bedside that are labeled with the resident's name on it. The DON also includes if there is a disgruntled resident that doesn't want to take their medicine right then, she advises them that she can't leave the medication unattended in the room and there is a certain amount of time that she has before they are discarded. Late entries are only documented when medications are given late. The DON explains that her expectations are for staff to always follow policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425032	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER: Magnolia Manor - Inman		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 - Immediate jeopardy to resident health or safety 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** 49918 Based on review of facility policy, record review, and interviews, the facility failed to protect Resident (R)11 from neglect, by failing to administer (R)11's physician ordered antibiotics, resulting in loss of limb. On 12/19/24 at 10:10 AM, the Administrator was notified that the failure to administer physician ordered antibiotics as treatment for a Pressure Ulcer (PU)/Pressure Injury (PI), constituted IJ at F600. On 12/19/24 at 10:10 AM, the survey team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template, informing the facility IJ existed as of 11/21/24. The IJ was related to 42 CFR 483.12 - Freedom from Abuse, Neglect, and Exploitation. On 12/19/24, the facility provided an acceptable IJ Removal Plan. On 12/19/24, the survey team, validated the facility's corrective actions and removed the IJ. The facility remained out of compliance at F600 at a lower scope and severity of D. An extended survey was conducted in conjunction with the Complaint Survey for non-compliance at F600, constituting substandard quality of care. Findings include: Review of the facility's policy titled, Medication Management Program revised on 05/05/23, documented, The facility implements a Medication Management Program to meet the pharmaceutical needs of patients and residents, according to established standards of practice and regulatory requirements. The following scope and rules included: 1.The facility's Medical Director will have an active role in the oversight of medication management, achieved in a variety of ways including medical record reviews, consultation, recommendations from pharmacy consultants and/or recommendations through the Quality Assurance and Performance Improvement process. 2. Licensed Independent Practitioners, licensed nurses, consulting pharmacists, and pharmacy service providers collaborate and review medication orders to ensure medical and clinical necessity and appropriateness. The primary mechanism for this validation is an initial and ongoing medication reconciliation process. 3. Licensed nurses will evaluate, assess, monitor, document and report the effectiveness of the medication regimen that includes all medications and supplements prescribed to treat illness, disease process, or enhance the patient's/resident's quality of life. Review of R11 's Face Sheet revealed R11 was admitted to the facility on [DATE], with diagnoses including but not limited to: Type 2 Diabetes Mellitus with a foot ulcer (Admission), PVD (peripheral vascular disease), Chronic Kidney Disease (CKD), Stage 3b (CMS/HCC) s/p unilateral above knee amputation, pain in left ankle and joints of left foot, acquired absence of right leg above knee. Review of R11's Wound Measurement dated 11/14/24, revealed a wound on her left lateral ankle; left heel: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425032	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Magnolia Manor - Inman		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Wound size [Length (L) x Width (W) x Depth (D)] 2.7 x 4.5 x 0.3 Surface Area 12.15 cm2 Exudate: Moderate Sero-Sanguinous Thick adherent black necrotic tissue (Eschar) 70% Slough 10% Other Viable tissues 20% (SubQ Muscle) Review of R11's Wound Measurements dated 11/21/24, revealed a diabetic wound of the left heal, full thickness: Wound Size (L x W x D) 3.0 x 4.4 x 0.3 cm Surface Area 13.20 cm2 Exudate Moderate Sero-sanguinous Thick adherent black necrotic tissue (eschar) 70% Other viable tissue 20% Review of a VOHRA Wound Physicians Wound Evaluation & Management Summary dated 11/21/24, revealed, Recommendation: Augmentin 875/125 mg BID x 14 days. Probiotics TID x 45 days. Review of R11's Medication Administration Record (MAR), did not reveal an order for Augmentin 875/125 mg. Review of R11's Physician Orders did not reveal an order for Augmentin 875/125 mg BID x 14 days or Probiotics TID x 45 days. Review of R11's Care Plan with a start date of 06/09/17, documented, At risk for *IMPAIRED SKIN INTEGRITY* Related To (R/T): *Bowel and Bladder incontinence *Assist. with toileting needs *Assist. in bed mobility *Assist with toileting needs *Risk of developing pressure ulcer *Diagnosis (Dx). of PVD *Dx. of Contracture rt hand *Dry skin *Sciatica. Further review of the Care Plan revealed the following approach, [R11] will maintain skin integrity As Evidence By (AEB) no skin breakdown or signs of skin breakdown through target date. Notify Medical Doctor (MD) of any significant changes in skin integrity. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425032	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Magnolia Manor - Inman		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 12/18/24 at 11:24 AM, Licensed Practical Nurse (LPN)1 stated, [R11] already had an Above the Knee Amputee (AKA) who developed wounds to her left heel and her left lateral ankle malleolus. Routinely we were keeping ithe wounds stable. [R11's] interventions included an air mattress and wound boots from the start. After a few weeks we started to see additional break down of those wounds. [R11's] periwounds became inflamed and angry. [R11] had the trifecta of wound healing issues. [R11] had a diagnosis of Diabetes Mellitus (DM), Peripheral Vascular and Arterial Disease so we were working with her aggressively. When we noticed draining of the wounds the MD ordered an antibiotic because she was concerned an underlying infection was starting due to [R11's] high risk comorbidities. On Thursdays every week we round on the residents. I try my best to have her orders and measurements entered into the computer. If I don't, I will try to wrap up on Fridays. I will admit I missed entering the antibiotic order in Matrix (electronic medical record). I feel awful about it. The wound care MD noticed the antibiotic was not entered in Matrix the following week. I totally missed it. The MD was concerned so she sent [R11] out to [local hospital] because the wound looked worse, in lieu of interventions of using the wound boots and air mattress. I have conducted in-services with 4 nurses, unfortunately it has been numerous times when dressings have come off or have not been changed or replaced. When I am off on leave the primary nurses are responsible for wound care. I usually have 15 to 20 plus patients a day for wound changes. During an interview on 12/18/24 at 12:46 PM, R11's Resident Representative (RR) stated, They called me about her wound. The facility stated they thought it needed to be looked at and they needed more medication to treat her wound. Then I noticed she had a hole in her left leg. Since she has been at that facility, she now has had both legs amputated. Her left leg was amputated on November 22, 2024. We spoke with [local hospital] and they made the decision to remove the left leg on that day or the next day. They ended up going above the knee to amputate. I think they ended up doing the surgery on November 23rd or 24th. The first text I received from [LPN1] was November 21st. [R11] went to the hospital the same day. It was 2 days before that, they called. A telephone number kept coming up, but it came up as spam. The spam number did not leave a message. It was [LPN1] the wound care specialist who told me about the wounds they were treating, and they needed to give her antibiotics. [LPN1] stated they had to send her to the hospital to give the antibiotics since they couldn't administer it there at the facility. During an interview on 12/18/24 at 1:24 PM, the Interim Director of Nursing (DON) stated, I heard about it. I know [R11] went to the hospital. The wound was healing, but day after day it got worse. During an interview on 12/18/24 at 2:18 PM, the MD stated, The week before I ordered Augmentin. I entered the note, and I guess it was not entered. I don't know what happened. The next week I assessed [R11] and observed the wound was getting worse. I decided to send her to the hospital. I am subcontracted out for services. We are unable to enter orders into their system. The wound deteriorated and had exudate, so we covered [R11] with a broad-spectrum antibiotic. I think we did a culture on her at that time. The wound deteriorated, I can't say by not receiving the antibiotic what [R11's] outcome would be. I can't answer that question without knowing the updates on her progress. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425032	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Magnolia Manor - Inman		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 12/18/24 at 2:50 PM, the Nurse Practitioner (NP) stated, The way the wound doctor functions is she uploads her notes in Matrix and the Wound Nurse is responsible for putting the orders in Matrix. I don't know who the Wound MD is in the facility. The old Wound MD would let me know who they vistited, but the new Wound MD doesn't let me know of any interactions between her and the Wound Nurse. The only way I find out about any new orders is reviewing the Wound MD's note that is entered into Matrix. The only thing I did notice was they were not entering orders in Matrix. I informed the old DON of orders not being entered into the system. I have noticed orders being missed on other residents as well. During an interview on 12/18/24 at 3:09 PM, RR stated, This visit to the hospital prior to Magnolia Manor - [NAME] were to treat her for wounds on her foot. I was notified by the [NP] about the wound. The wound was still not healing, and it turned black. [R11] should have had care before she received wound #2. Wound #2 was open to the bone. The bone was exposed. Something should have been done prior to them sending her to the hospital. She doesn't complain of pain. But [R11] will groan. That is how I know she is in pain. When at the hospital the hospital doctors stated the wound was infected and they needed to remove the leg. We had a conversation prior to this occurring with Magnolia Manor - [NAME] to ensure [R11] established a team to work with her that knows her. So that she can receive consistent care. I had the meeting with the staff that included the head of nursing. The RR was unable to state the others who attended the meeting. RR continued, We established a protocol so we shouldn't have to go through this again after the amputation of the first leg. Now it has happened again. I don't understand why this has happened again. The first wound wasn't doing what it should be doing. If the first wound wasn't healing and clearing up appropriately. Especially since she is diabetic, the second wound should have been aggressively treated so this would not happen again. I found out about wound #2 at the hospital. The last email from the NP was September 23, 2024. They amputated [R11's] leg on November 25, 2024. During an interview with the Administrator on 12/18/24 at 5:35 PM, the Administrator stated, My expectations going forward is to get an exit interview with the Wound MD every visit. I was not aware this was going on. I will get updated from both the Wound Physician and NP on all interventions. I will look at all reports of treatments and orders and ensure they are carried out as expected. On 12/19/24, the facility provided an acceptable IJ Removal Plan, which included: Resident #11 no longer resides in the facility. An audit of notes from the wound physician's current resident list was completed by The Director of Nursing/Designee on 12/18/2024 to identify new physician orders. None identified. An audit of medication administration was completed by the Director of Nursing/Designee on 12/18/2024 for medications and treatments 12/01/2024 through 12/18/2024 to identify missed medications and/or treatments. None identified. Licensed nurses were reeducated on Abuse and Neglect, transcribing and following physician orders including notifying responsible party of new orders by the Director of Nursing/Designee on 12/18/2024. Licensed Nurses not receiving this education by 12/19/2024 will receive prior to their next scheduled shift and this will be completed in New Hire and agency orientation. (continued on next page)

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	12/19/2024

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Director of Nursing/Designee will review wound physician's notes in clinical morning meeting Monday - Friday beginning 12/20/2024 until 01/10/2025 to validate recommend orders have been transcribed, implemented, responsible party notified, and care plan updated. Director of Nursing/Designee will review wound physician's notes in clinical morning meeting Monday - Friday beginning 12/20/2024 until 01/10/2025 to validate updated wound measurements have been documented in the medical record, responsible party notified and care plan updated. These weekly audits will be monitored by the Administrator and brought for review to the next Quality Assurance and Performance Committee meeting for recommendations and this will continue for 2 additional months. Ad Hoc QAPI will be held on 12/19/2024. The Medical Director was notified of the Immediate Jeopardy on 12/19/2024. Allegation of Compliance Date is 12/19/2024.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425032	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Magnolia Manor - Inman		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49918 Based on review of facility policy, record review and interviews, the facility failed to provide treatment, consistent with professional standards of practice for Resident (R)11's Pressure Ulcer (PU)/Pressure Injury (PI). Specifically, the facility failed to administer an antibiotic to treat R11's wounds, resulting in a loss of limb. On 12/19/24 at 10:10 AM, the Administrator was notified that the failure to provide treatment, consistent with professional standards of practice, to a Pressure Ulcer (PU)/Pressure Injury (PI), constituted IJ at F686. On 12/19/24 at 10:10 AM, the survey team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template, informing the facility IJ existed as of 11/21/24. The IJ was related to 42 CFR 483.25 Quality of Care. On 12/19/24, the facility provided an acceptable IJ Removal Plan. On 12/19/24, the survey team, validated the facility's corrective actions and removed the IJ. The facility remained out of compliance at F686 at a lower scope and severity of D. An extended survey was conducted in conjunction with the Complaint Survey for non-compliance at F686, constituting substandard quality of care. Findings include: Review of the facility's policy title, Wound Care Policies and Procedures Reference dated 09/2024, documented, All treatments should be in conjunction with a physician's order . Physician Orders will still be Required for Wound Care . Review of the facility's policy titled, Medication Management Program, revised 05/05/2023, revealed, The facility implements a Medication Management Program to meet the pharmaceutical needs of patients and residents, according to established standards of practice and regulatory requirements. The following scope and rules included: 1.The facility's Medical Director will have an active role in the oversight of medication management, achieved in a variety of ways including medical record reviews, consultation, recommendations from pharmacy consultants and/or recommendations through the Quality Assurance and Performance Improvement process. 2. Licensed Independent Practitioners, licensed nurses, consulting pharmacists, and pharmacy service providers collaborate and review medication orders to ensure medical and clinical necessity and appropriateness. The primary mechanism for this validation is an initial and ongoing medication reconciliation process. 3. Licensed nurses will evaluate, assess, monitor, document and report the effectiveness of the medication regimen that includes all medications and supplements prescribed to treat illness, disease process, or enhance the patient's/resident's quality of life. Review of R11's Face Sheet revealed R11 was admitted to the facility on [DATE], with diagnoses including but not limited to: Type 2 Diabetes Mellitus with a foot ulcer (Admission), PVD (peripheral vascular disease), Chronic Kidney Disease (CKD), Stage 3b (CMS/HCC) s/p unilateral above knee amputation, pain in left ankle and joints of left foot, acquired absence of right leg above knee. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425032	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Magnolia Manor - Inman		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of (R)11's Physician Orders revealed the following: Sodium hypochlorite solution (Dakins apply once daily for 30 days. Use 1/4 Dakin's, lightly wet gauze for Wet to Dry (WTD). Do not wet to remove. Remove dry bandage quick like a band aid with necrotic tissue attached. Acetic acid apply once daily for 30 days clean wound with acetic acid. Secondary Tape (retention) apply once daily for 23 days; Gauze roll (stretch) 6 apply once daily for 23 days wrap from beneath toes to mid-calf to attempt to keep resident from being able to remove; Super absorbent gelling fiber pad apply once daily for 9 days. Review of a VOHRA Wound Physicians Wound Evaluation & Management Summary dated 11/14/24, order revealed dressing treatment plan (Diabetic Wound of Left, Lateral Ankle Full Thickness). Sodium (Na) hypochlorite solution (Dakins) apply once daily for 30 days; Use 1/4 Dakins, lightly wet gauze and cover wound with wet gauze for WTD. Do not wet to remove. Remove dry bandage quick like a band-aid with necrotic tissue attached. Acetic acid apply once daily for 30 days clean wound with acetic acid. Review of a VOHRA Wound Physicians Wound Evaluation & Management Summary dated 11/21/24, revealed the following: Recommendation: Augmentin 875/125 mg Twice a Day (BID) x 14 days. Probiotics Three times a day (TID) x 45 days. Review of R11's Wound Measurement dated 11/14/24, revealed a wound on her left lateral ankle; left heel: Wound size [Length (L) x Width (W) x Depth (D)] 2.7 x 4.5 x 0.3 Surface Area 12.15 cm2 Exudate: Moderate Sero-Sanguinous Thick adherent black necrotic tissue (Eschar) 70% Slough 10% Other Viable tissues 20% (SubQ Muscle) Review of R11's Wound Measurements dated 11/21/24, revealed a diabetic wound of the left heal, full thickness: Wound Size (L x W x D) 3.0 x 4.4 x 0.3 cm Surface Area 13.20 cm2 Exudate Moderate Sero-sanguinous Thick adherent black necrotic tissue (eschar) 70% Other viable tissue 20% Review of R11's Medication Administration Record (MAR), did not reveal an order for Augmentin 875/125 mg. (continued on next page)

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 03/01/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425032	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Magnolia Manor - Inman		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R11's Physician Orders did not reveal an order for Augmentin 875/125 mg BID x 14 days or Probiotics TID x 45 days. Review of R11's Care Plan with a start date of 06/09/17, documented, At risk for *IMPAIRED SKIN INTEGRITY* Related To (R/T): *Bowel and Bladder incontinence *Assist. with toileting needs *Assist. in bed mobility *Assist with toileting needs *Risk of developing pressure ulcer *Diagnosis (Dx). of PVD *Dx. of Contracture rt hand *Dry skin *Sciatica. Further review of the Care Plan revealed the following approach, [R11] will maintain skin integrity As Evidence By (AEB) no skin breakdown or signs of skin breakdown through target date. Notify Medical Doctor (MD) of any significant changes in skin integrity. During an interview on 12/18/24 at 11:24 AM, Licensed Practical Nurse (LPN)1 stated, [R11] already had an Above the Knee Amputee (AKA) who developed wounds to her left heel and her left lateral ankle malleolus. Routinely we were keeping the wounds stable. [R11's] interventions included an air mattress and wound boots from the start. After a few weeks we started to see additional break down of those wounds. [R11's] periwounds became inflamed and angry. [R11] had the trifecta of wound healing issues. [R11] had a diagnosis of Diabetes Mellitus (DM), Peripheral Vascular and Arterial Disease so we were working with her aggressively. When we noticed draining of the wounds the MD ordered an antibiotic because she was concerned an underlying infection was starting due to [R11's] high risk comorbidities. On Thursdays every week we round on the residents. I try my best to have her orders and measurements entered into the computer. If I don't, I will try to wrap up on Fridays. I will admit I missed entering the antibiotic order in Matrix (electronic medical record). I feel awful about it. The wound care MD noticed the antibiotic was not entered in Matrix the following week. I totally missed it. The MD was concerned so she sent [R11] out to [local hospital] because the wound looked worse, in lieu of interventions of using the wound boots and air mattress. I have conducted in-services with 4 nurses, unfortunately it has been numerous times when dressings have come off or have not been changed or replaced. When I am off on leave the primary nurses are responsible for wound care. I usually have 15 to 20 plus patients a day for wound changes. During an interview on 12/18/24 at 12:46 PM, R11's Resident Representative (RR) stated, They called me about her wound. The facility stated they thought it needed to be looked at and they needed more medication to treat her wound. Then I noticed she had a hole in her left leg. Since she has been at that facility, she now has had both legs amputated. Her left leg was amputated on November 22, 2024. We spoke with [local hospital] and they made the decision to remove the left leg on that day or the next day. They ended up going above the knee to amputate. I think they ended up doing the surgery on November 23rd or 24th. The first text I received from [LPN1] was November 21st. [R11] went to the hospital the same day. It was 2 days before that, they called. A telephone number kept coming up, but it came up as spam. The spam number did not leave a message. It was [LPN1] the wound care specialist who told me about the wounds they were treating, and they needed to give her antibiotics. [LPN1] stated they had to send her to the hospital to give the antibiotics since they couldn't administer it there at the facility. During an interview on 12/18/24 at 1:24 PM, the Interim Director of Nursing (DON) stated, I heard about it. I know [R11] went to the hospital. The wound was healing, but day after day it got worse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425032	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 12/18/24 at 2:18 PM, the MD stated, The week before I ordered Augmentin. I entered the note, and I guess it was not entered. I don't know what happened. The next week I assessed [R11] and observed the wound was getting worse. I decided to send her to the hospital. I am subcontracted out for services. We are unable to enter orders into their system. The wound deteriorated and had exudate, so we covered [R11] with a broad-spectrum antibiotic. I think we did a culture on her at that time. The wound deteriorated, I can't say by not receiving the antibiotic what [R11's] outcome would be. I can't answer that question without knowing the updates on her progress. During an interview on 12/18/24 at 2:50 PM, the Nurse Practitioner (NP) stated, The way the wound doctor functions is she uploads her notes in Matrix and the Wound Nurse is responsible for putting the orders in Matrix. I don't know who the Wound MD is in the facility. The old Wound MD would let me know who they visited, but the new Wound MD doesn't let me know of any interactions between her and the Wound Nurse. The only way I find out about any new orders is reviewing the Wound MD's note that is entered into Matrix. The only thing I did notice was they were not entering orders in Matrix. I informed the old DON of orders not being entered into the system. I have noticed orders being missed on other residents as well. During an interview on 12/18/24 at 3:09 PM, RR stated, This visit to the hospital prior to Magnolia Manor - [NAME] were to treat her for wounds on her foot. I was notified by the [NP] about the wound. The wound was still not healing, and it turned black. [R11] should have had care before she received wound #2. Wound #2 was open to the bone. The bone was exposed. Something should have been done prior to them sending her to the hospital. She doesn't complain of pain. But [R11] will groan. That is how I know she is in pain. When at the hospital the hospital doctors stated the wound was infected and they needed to remove the leg. We had a conversation prior to this occurring with Magnolia Manor - [NAME] to ensure [R11] established a team to work with her that knows her. So that she can receive consistent care. I had the meeting with the staff that included the head of nursing. The RR was unable to state the others who attended the meeting. RR continued, We established a protocol so we shouldn't have to go through this again after the amputation of the first leg. Now it has happened again. I don't understand why this has happened again. The first wound wasn't doing what it should be doing. If the first wound wasn't healing and clearing up appropriately. Especially since she is diabetic, the second wound should have been aggressively treated so this would not happen again. I found out about wound #2 at the hospital. The last email from the NP was September 23, 2024. They amputated [R11's] leg on November 25, 2024. During an interview with the Administrator on 12/18/24 at 5:35 PM, the Administrator stated, My expectations going forward is to get an exit interview with the Wound MD every visit. I was not aware this was going on. I will get updated from both the Wound Physician and NP on all interventions. I will look at all reports of treatments and orders and ensure they are carried out as expected. On 12/19/24, the facility provided an acceptable IJ Removal Plan, which included the following: Resident #11 no longer resides in the facility. An audit of notes from the wound physician's current resident list was completed by The Director of Nursing/Designee on 12/19/2024 to identify new physician orders. None identified. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425032	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An audit of current wound treatment orders and wound physician notes will be completed on 12/19/2024 by the Director of Nursing/designee to validate wound treatments have been implemented as recommended by wound physician. An audit of medication administration was completed by the Director of Nursing/Designee on 12/1/2024 for medications and treatments 12/01/2024 through 12/18/2024 to identify missed medications and/or treatments. None Identified. Licensed nurses were reeducated on Abuse and Neglect, transcribing and following physician orders including notifying responsible party of new orders by the Director of Nursing/Designee on 12/18/2024. Licensed nurses will receive reeducation on wound care by the Director of Nursing/Designee by 12/19/2024 including: -Transcribing physician wound treatment orders from wound physician notes -Providing treatment and care per physician's order Licensed Nurses not receiving this education by 12/19/2024 will receive prior to their next scheduled shift and this will be completed in New Hire and agency orientation. Director of Nursing/Designee will review wound physician's notes in clinical morning meeting Monday-Friday beginning 12/20/2024 through 01/10/2025 to validate any recommended orders have been transcribed, implemented, responsible party notified, and care plan updated. Director of Nursing/Designee will review wound physician's notes in clinical morning meeting Monday-Friday beginning 12/20/2024 through 01/10/2025 to validate updated wound measurements have been documented in the medical record, responsible party notified, and care plan updated. These weekly audits will be monitored by Administrator and brought for review to the next Quality Assurance and Performance Committee meeting for recommendations and this will continue for 2 additional months. Ad Hoc QAPI will be held on 12/18/2024. The Medial Director was notified of the Immediate Jeopardy on 12/18/2024. Allegation of Compliance Date is 12/19/2024