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	06/05/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on review of the facility policy, record review, and interview, the facility failed to report an allegation of elopement that occurred on 04/28/25. Specifically, Resident (R)1 eloped two separate times from the facility on 04/28/25 and the facility failed to report the elopement. Findings include: Review of the facility policy titled Elopement with a complete revision date of 11/01/2017, documents, To safely and timely redirect patients/residents to a safe environment. The Director of Nursing or designee notifies the Administrator/designee and notifies the appropriate agencies, attending physician, and the patient's/resident's legal representative. The Facility leadership contacts their Regional [NAME] President of Operations and their Clinical Services Director for recommendations at the time of the elopement. Review of R1's Progress Notes dated 04/28/25, revealed, 3:29 PM-Resident was seen going out of door 5 she was immediately followed by staff we did not see her anywhere in the parking lot I went back in to get more nurses once back outside I saw the resident laying in the middle of the road I called for her to be sure it was her as it was dark and I could not see after getting no response I went in the road and it was [R1] so me and 2 other nurses talked to her and got her to get up and follow us inside where she continued to try to escape so me and a certified nursing assistant (CNA) kept her at the nurses station and when we no longer could do so she got to her room where a CNA sat outside the door to watch her. The DON and unit manager were alerted at the time of the incident. Review of R1's Progress Note dated 04/28/25 at 7:09 PM, revealed, Resident noted missing after alarm was sounding on unit 2 and staff checked her room. She was noted walking in the staff parking lot on the side of the building heading to the front of the building. After running to catch up with her, she put herself on the ground and started yelling and kicking staff as several assisted her onto a wheelchair (WC), and she slid herself back onto the ground. The Nurse Practitioner (NP) and unit manager notified and per NP order received to transport resident to the ER for evaluation. Resident remained alert, no injuries noted at that time. Review of the INTERACT Nursing Home to Hospital Transfer Form/Situation Background Assessment Recommendation (SBAR) dated 04/28/25 at 4:43 PM, from Magnolia Manor, unit 2. The reason for transfer revealed, Elopement, Combative. Usual functional status- Ambulates independently. Risk alerts- Agitation with risk to harm to self or others, may attempt to exit, and seizures. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An attempt to contact R1's Resident Representative (RP) on 06/03/25 at 12:02 PM, was unsuccessful, the number was not in service. During an interview with the Administrator on 06/03/25 at 12:11 PM, revealed he has been in his role since last week, 05/28/25. The Administrator stated he was unaware of this event, and he has no facility investigation related to R1 and the events that occurred in April 2025. During a phone interview with Licensed Practical Nurse (LPN)1 on 06/03/25 at 12:38 PM, revealed she came in at 7 AM on 04/28/25, she was getting a report from LPN2 related to R1's elopement that occurred at 1:00 AM, and that R1 went out the back door on unit 2, was found in the street lying on the ground (main road). LPN1 revealed that while getting the report, R1 successfully eloped again around 7:00 AM. The alarms were going off, and another staff member went and checked R1's room; she was not there. Staff started looking for her, and R1 was found in the parking lot within line of sight and was redirected back to the building. LPN1 stated that CNA1 was able to redirect R1 into the building via a non-mechanical wheelchair. LPN1 further stated protocol is to report to the Director of Nursing (DON) and Administrator. LPN1 confirmed that R1 successfully eloped the building twice on 04/28/25. During an interview with LPN2 on 06/03/25 at 1:04 PM, LPN2 stated that on 04/28/25, around midnight, R1 was wandering throughout the building. That night, she exited door 5, which is located in unit 2, which is 4-5 rooms down from her room. The alarm goes off. She and the agency CNA (unable to recall name) split up and looked for her. R1 was not found on the premises. Staff came back in the building, got more staff, 2 nurses from stations 3 & 4, and went back out the front door. LPN2 stated she saw a dark shadow on the main road. LPN2 stated she called R1's name out, and she would not respond. LPN2 walked up to the dark shadow and confirmed that it was R1; she was found alert/responsive and ignoring LPN2. LPN2 stated staff tried talking to her, told her she can't lie in the middle of the road because it's dark and dangerous. LPN2 stated that following the incident, the unit manager was contacted, and DON, who instructed her to do a body audit, a full skin assessment. No injuries were noted following the incident. A progress note and Sbar were completed. R1 did not go out to the hospital at that time; however, she was sent after she eloped again at 7:00 AM, for behaviors. LPN2 concluded she was told to do a witness statement and which was given to the previous Administrator. An attempted phone interview with the previous Administrator on 06/03/25 at 1:45 PM, was unsuccessful, call forwarded to voicemail. A detailed message was left for a return phone call. During an interview with the Unit Manager (UM) on 06/03/25 at 1:57 PM, revealed, I am the Unit Manager. However, I have no knowledge about this. I got notified by [LPN2] that [R1] got out at 1:00 AM, I was not physically in the building. I told her to notify the DON and to make sure the resident was brought back in the building, and someone was to sit with the resident until we can come together as a team and see how the situation can be corrected, and she became 1 on 1. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 06/03/25 at 3:35 PM, revealed she is aware of the incident. The DON stated she was notified when she arrived for her shift. The DON was told R1 got out, staff heard the door, staff looked for her, and staff found her lying on the main road. The DON stated she was also told R1 eloped again, right before she arrived for her shift. The DON stated she had notified her Administrator at the time and thought the situation was reported. The DON also stated she and the Administrator at the time spoke with the Nurse Consultant, who told them that the incident was not to be reported because there is a fine line between federal and state regulations. The DON followed the chain of command. The DON stated she did what she could to protect the resident at the time. The DON stated the facility should have reported both incidents. The DON further stated she cannot override the chain of command; the Administrator at that time could have overridden the Nurse Consultant's decision. During an interview with the facility's Regional Regulatory Compliance Consultant, RRCC on 06/03/25 at 4:03 PM, revealed she had no knowledge of the event regarding R1, she was told about it when she arrived. The RRCC stated as consultants, they can only go by what information is given to them. It could have been a life-or-death situation. The RRCC stated staff need to follow the policy, investigate, and determine why or why not they didn't do what they were supposed to do. The understanding from staff is that R1 was within line of sight, which is why it was not reported. The facility is its own entity, so the facility does not have to consult with consultants when it comes to reporting.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility's policy, record review, and interview, the facility failed to provide documentation to that a proper investigation was conducted regarding an incident that occurred on 04/12/2025 involving an allegation of staff-to-resident abuse concerning Resident (R2). Findings include: A review of the facility policy titled Abuse, Neglect, Exploitation, or Mistreatment states: Investigations are prompt, comprehensive, and responsive to the situation and contain founded conclusions. The investigation may include but is not limited to, the following: Identification and removal of the alleged perpetrators. Identification of the alleged victim. Type of alleged abuse. Where and when the incident occurred. Written summaries of interviews with individuals having first-hand knowledge of the incident. NOTE: Employees/witnesses are not to write out statements. Employees/witnesses will be interviewed by designated facility staff, and the interviewer will record all witness accounts in a document, written, dated, and signed by the interviewer. Resolution/outcome. Measures taken to prevent future incidents. All documents pertaining to the investigation must be compiled and stored in the administrator's office. Review of R2's Face Sheet revealed R2 was admitted to the facility on [DATE], with diagnoses including, but not limited to: Cerebral Palsy, adult failure to thrive, cortical blindness, and epilepsy. Review of R2's Annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 05/14/25, revealed R2's Brief Interview for Mental Status (BIMS) could not be assessed due to R2 never/rarely being understood. Review of R2's Progress Notes documented by Licensed Practical Nurse (LPN)4 revealed, 04/12/2025 05:56 PM -Resident alert place in wheelchair. Writer was made aware by staff that resident mother not supposed to be in the resident room visiting with her due to Past history and that the visitation should be supervise by staff. After ADL's writer administer resident Meds., and proceeded to transport resident to the area to visit with her Mother. Writer begun to apologized letting mother know that medication needed to be administer then she started yelling what did you all did to her arm. Writer stated i don't know what happen but I could find out for you. Mother stated in a accusative voice you know exactly what happen. Writer told the mother let me get someone to supervise with you. I took resident away from by her due her aggressiveness, before walking off. Later returning to the nurses station writer was told that mother was contacting the Police. During an interview with the current Administrator on 06/04/25 at 9:59 AM, in the presence of the Regional Regulatory Compliance Consultant (RRCC) revealed that there is no investigative file found related to R2 and the incident that occurred on 04/12/25. The Administrator stated that all he could locate and provide was the 5-Day Follow-up, and to follow up with the Director of Nursing (DON) since she has been in her role longer. The Administrator stated his expectation is for all reportable files to be investigated thoroughly and for all reportable files to remain in the building for situations like this. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Multiple attempts to interview R2's Resident Representative (RP), which is also her R2's mother, on 06/04/25 at 11:00 AM and 11:22 AM were unsuccessful. The phone number was disconnected and is no longer in service. Multiple attempts to interview Licensed Practical Nurse (LPN)4 on 06/04/25 at 11:10 AM, 1:05 PM, and 1:18 PM, were unsuccessful. Voicemail box was full and unable to leave a detailed message. An additional attempt was made on 06/05/25 at 10:55 AM, which was unsuccessful. Multiple attempts to interview R2's Department of Social Services Caseworker, RP/Emergency Contact 2, on 06/04/25 at 11:27 AM and 11:32 AM, was unsuccessful, a detailed message was left for a return call. During an interview with the DON on 06/04/25 at 10:03 AM, revealed that she is familiar with R2 and the incident that occurred on 04/12/25. The DON stated facility staff are aware that R2's mother is not allowed to visit the resident unsupervised. R2 is overseen by a DSS caseworker due to mistreatment at home prior to admission. R2's mother visited her on 04/12/25 and saw scratches and redness on R2's left upper arm. R2's mother alleged that the scratches and redness on R2's left arm were the result of abuse by a staff member. Law enforcement was notified, and the case ended up being unfounded and closed. There were no witnesses to the alleged event. R2 is care planned for involuntary movements to the UE (Upper Extremity) and has a history of scratching herself. The physician was notified, but there were no changes in medications or treatments. The DON stated that regarding the reportable file, the previous administrator had the reportable file. It is unknown why we can't find it. All reportables were kept in the administrator's office. The DON stated she could not provide any documentation related to the investigation.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 review of facility policy, interview and record review, the facility failed to ensure that Resident (R)1 was provided appropriate supervision to prevent 2 separate elopements from the facility on 04/28/25. On 06/03/25 at 5:53 PM, the Administrator and the Director of Nursing were notified that the failure to ensure that Resident (R)1 was free from two separate elopement incidents from the facility on 04/28/25, constituted Immediate Jeopardy (IJ) at F689. On 06/03/25 at 5:53 PM, the survey team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template and informed the facility that IJ existed as of 04/28/25. The IJ was related to 42 CFR 483.25 - Quality of Care. On 06/04/25 at 11:54 AM, the facility provided an acceptable IJ Removal Plan. On 06/04/25 at 12:28 PM, the survey team validated the facility's corrective actions and removed the IJ. The facility remained out of compliance at F689 at a lower scope and severity of D. An extended survey was conducted in conjunction with the Complaint Survey for non-compliance at F689, constituting substandard quality of care. Findings Include: Review of the facility policy titled Elopement with a complete revision 11/01/2017 states, To safely and timely redirect patients/residents to a safe environment. Review of R1's Face Sheet revealed R1 was admitted to the facility on [DATE], with diagnoses including but not limited to: restlessness and agitation, Schizophrenia, anxiety disorder, conversion disorder with seizures or convulsions, and moderate intellectual disabilities. Review of R1's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/20/25, revealed R1 had a Brief Interview for Mental Status (BIMS) score of 4 out of 15, which indicates she was severely cognitively impaired. Further review of the MDS revealed that R1 had no wandering behaviors during the assessment period. Review of R1's Progress Note dated 04/28/25, revealed, 3:29 PM-Resident was seen going out of door 5 she was immediately followed by staff we did not see her anywhere in the parking lot. I went back in to get more nurses once back outside I saw the resident laying in the middle of the road I called for her to be sure it was her as it was dark and I could not see after getting no response I went in the road and it was [R1] so me and 2 other nurses talked to her and got her to get up and follow us inside where she continued to try to escape so me and a certified nursing assistant (CNA) kept her at the nurses station and when we no longer could do so she got to her room where a CNA sat outside the door to watch her. The DON [Director of Nursing] and unit manager were alerted at the time of the incident. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R1's Progress Note dated 04/28/25 at 7:09 PM, revealed, Resident noted missing after alarm was sounding on unit 2 and staff checked her room. She was noted walking in the staff parking lot on the side of the building heading to the front of the building. After running to catch up with her, she put herself on the ground and started yelling and kicking staff as several assisted her onto a wheelchair (WC), and she slid herself back onto the ground. The Nurse Practitioner (NP) and unit manager notified and per NP order received to transport resident to the ER for evaluation. Resident remained alert, no injuries noted at that time. Review of the INTERACT Nursing Home to Hospital Transfer Form/Situation Background Assessment Recommendation (SBAR) dated 04/28/25 at 4:43 PM, from Magnolia Manor, unit 2, revealed the reason for the transfer states - Elopement, Combative. Usual functional status- Ambulates independently. Risk alerts- Agitation with risk to harm to self or others, may attempt to exit, and seizures. Review of Quarterly Nursing - Elopement Risk Observation dated 03/11/25 at 1:10 PM, revealed R1 has a history of wandering, has attempted to leave the health care center, has expressed a desire to leave the health care center, and has a diagnosis that requires supervision. During an interview with the Nurse Consultant in the presence of the current Administrator on 06/03/25 at 12:09 PM, revealed she is aware of the incident with R1 eloping from the building. The Nurse Consultant stated she heard this from either the Director of Nursing or the previous Administrator, however, she can't recall. The Nurse Consultant stated she was told R1 got out of the building while being in line of sight, R1 then placed herself on the ground, and was able to be re-directed back in the building. During an interview with the current Administrator on 06/03/25 at 12:11 PM, revealed that he has been in his role since last week, 05/28/25 and was unaware of this event. During a phone interview with Licensed Practical Nurse (LPN)1 on 06/03/25 at 12:38 PM, revealed she came in at 7:00 AM on 04/28/25, she was getting a report from LPN2 related to R1's elopement that occurred at 1:00 AM, and that R1 went out the back door on unit 2, was found in the street lying on the ground (main road). LPN1 revealed that while getting the report, R1 successfully eloped again around 7:00 AM. The alarms were going off, and another staff member went and checked R1's room; she was not there. Staff started looking for her, and R1 was found in the parking lot within line of sight and was redirected back to the building. LPN1 stated that CNA1 was able to redirect R1 into the building via a non-mechanical wheelchair. LPN1 confirmed that R1 successfully eloped the building twice on 04/28/25. During an interview with LPN2 on 06/03/25 at 1:04 PM, LPN2 stated on 04/28/25, around midnight, R1 was wandering throughout the building. That night, she exited door 5, which is located in unit 2, which is 4-5 rooms down from her room. The alarm goes off. She and the agency CNA (unable to recall name) split up and looked for her. R1 was not found on the premises, staff came back in the building, got more staff, 2 nurses from stations 3 & 4, and went back out the front door. LPN2 stated she saw a dark shadow on the main road. LPN2 stated she called R1's name out, and she would not respond. LPN2 walked up to the dark shadow and confirmed that it was R1; she was found alert/responsive, and ignoring LPN2. LPN2 stated staff tried talking to her, told her she can't lay in the middle of the road because it's dark and dangerous. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the Director of Nursing (DON) on 06/03/25 at 3:35 PM, revealed that she is aware of the incident related to R1. The DON stated she found out from the nurses, LPN2 specifically, and an agency nurse. The DON was told she got out, and staff looked for her and found her laying on the main road. The DON stated she was also told R1 eloped again, right before she arrived at her shift at around 7:00 AM. On 06/04/25 at 11:54 AM, the facility provided an acceptable IJ Removal Plan, which included the following: Resident #1 was placed on room supervision after elopement attempt on 4/28/25 at approximately 1am. Room supervision consisted of visual observation of resident's room and supervision was interrupted during change of shift. Resident #1 was sent to emergency department for evaluation after elopement attempt at 7am. Upon return placed on 1:1 supervision remains on 1:1 supervision. Staff education provided regarding Resident Exit Seeking and Elopement Prevention on 4/30/25. Elopement Risk evaluations done in the past 90 days on current residents inhouse will be reviewed by Director of Nursing/Designee for accuracy by 6/3/25. Residents identified at risk will be reviewed for appropriate interventions including placement in the Elopement Binder and validated care plans have interventions listed. The Director of Nursing was reeducated by the Clinical Consultant on 6/3/25 on Accidents and Incidents including: -elopement process and the elopement binder -elopement risk assessment process and putting interventions in place based on risks identified. All Facility Staff will be reeducated by 6/4/25 by the Director of Nursing/Designee on Accidents and Incidents including: -elopement process and the elopement binder Licensed Nurses will be reeducated by 6/3/25 by the Director of Nursing on the elopement risk assessment process and putting interventions in place based on risks identified. Any staff not receiving this education by 6/4/25 will receive prior to working the next scheduled shift. This will be presented in New Hire Orientation. The Director of Nursing will randomly interview a minimum of 2 staff daily to validate understanding of elopement risk and elopement binder. Interviews will continue for 30 days then 2 staff 3 times per week for an additional 60 days. Results of the audits will be review monthly during QAPI meeting. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Director of Nursing/Designee will review the facility activity report beginning 6/4/25 in clinical morning meeting to identify documentation and/or elopement risk assessments that may suggest a resident is exit seeking. If identified, the Director of Nursing/Designee will validate interventions are appropriate and care plan is updated. The Director of Nursing/Designee will review new admission elopement risk assessments in Clinical Morning Meeting beginning 6/4/25 for accuracy and interventions validated if indicated, including placement in the elopement binder and education to staff. The Medical Director was notified on 6/3/25 of the Immediate Jeopardy. An Ad Hoc Quality Assurance and Performance Improvement Meeting was held on 6/4/25 to discuss contents of this plan. Administrator will oversee compliance of this plan. Allegation of Compliance: 6/4/25