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	08/14/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to ensure the residents' code status preference was honored in that the physician's order did not match the code status preference on the residents' Physician Order for Life Sustaining Treatment (POLST) document for two (Resident (R)9 and R77) of five residents reviewed for code status. This failure had the potential to result in the residents not receiving lifesaving cardiopulmonary resuscitation (CPR).Findings include:Review of the facility's policy titled Advance Directives revised on [DATE] revealed, The facility's staff will inform the patient/resident about formulating an advance directive and will maintain written policies and procedures regarding advanced directives and Physician Order for Life Sustaining Treatment (POLST), or similar documents where applicable, including information on decisions involving resuscitative services and life-sustaining treatments.8. Obtain primary physician orders for the patient/resident advance directives, A POLST and some of the other forms are recognized as a valid physician's order, where applicable under state law. 9. POLST - Physician Orders for Scope of Treatment. All are the same concept as the POLST (Physician's Orders for Life- Sustaining Treatment) paradigm.1. Review of R9's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] located in the Resident Assessment Instrument (RAI) tab of the electronic medication record (EMR) revealed an admission date of [DATE], a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating R9 was cognitively intact, and diagnoses of tracheostomy status, chronic respiratory failure, unspecified whether with hypoxia or hypercapnia, and schizoaffective disorder, bipolar type.Review of R9's POLST dated [DATE] located in the EMR under the Resident Document tab revealed Attempt Resuscitation/CPR and Full Treatment were checked, and the form was signed by R9.Review of R9's Progress Note dated [DATE] located in the EMR under the Progress Note revealed Code Status: Full Code/Scope of Treatment. Review of R9's Orders dated [DATE] located in the EMR under the Order tab revealed Code Status: DNR [do not resuscitate]. Review of R9's Care Plan dated [DATE] located in the EMR under the RAI tab revealed Advanced Care Planning I DNR with an approach of Resident has completed the following advanced directives (x) DNR.During an interview on [DATE] at 5:40 PM, R9 was asked if her heart should stop, did she want someone to give her CPR to start it again. R9 stated, Yes, she wanted CPR. During an interview on [DATE] at 5:45 PM, the Social Services Assistant (SSA)2 was asked should the POLST and physician's order for code status match. The SSA2 stated, Yes. SSA2 was asked why R9's POLST code status did not match R9's physician order for code status. SSD2 reviewed the EMR and stated she wasn't aware of the discrepancy.During an interview on [DATE] at 5:50 PM, Licensed Practical Nurse (LPN)1 was asked what happens if a resident codes (found without a pulse). LPN1 stated she would check the Medication Administration Record (MAR) for the resident's code status and follow the physician's order. LPN1 was asked if they had a hard chart she would reference or check the POLST form. LPN1 stated there were no hard charts to check. LPN1 stated she was agency, and she didn't know what a POLST form was or where to find it.During an interview on [DATE] at 5:52 PM, LPN2 was asked what she would do if R9 coded. LPN2 stated she would check the code order in the computer and have someone else check the POLST form as she wasn't sure where it was located. 2. Review of R77's quarterly MDS with an ARD date of [DATE] located in the RAI tab of the EMR revealed an admission date of [DATE], a BIMS score of 15 out of 15, indicating R77 was cognitively intact and diagnoses of heart failure, chronic kidney disease, and hypertension. Review of R77's POLST dated [DATE] located in the EMR under the Resident Document tab revealed Attempt Resuscitation/CPR and Limited Treatment were checked. The form was signed by R77. Review of R77's Care Plan dated [DATE] located in the EMR under the RAI tab revealed Advanced Care Planning: Code Status DNR.Review of R77's Orders dated [DATE] located in the EMR under the Order tab revealed Code Status: DNR.During an interview on [DATE] at 6:14 PM, R77 was asked if her heart stopped, did she want someone to use CPR to start it again, as that was on her paperwork. R77 stated, Yes, CPR is okay, but not much more. R77 then asked if her paperwork was correct. R77 was informed that her POLST did list her wishes for CPR with limited treatment. During an interview on [DATE] at 6:52 PM, the Director of Nursing (DON) was asked how staff initially obtained a resident's code status. The DON stated upon admission, whether a resident came from the hospital or home, they would have a discussion with the resident or their representative about advance directives. The DON stated the social worker completes the POLST, and the resident or representative and physician sign the form. The DON stated a POLST should be

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, record review, and facility policy review, the facility failed to report blood sugar levels (BS) below 60 mg/dl (milligrams per deciliter) to the physician and failed to follow physician orders to hold insulin when the BS was below 100 mg/dl for one (Resident (R)87) of one resident reviewed for laboratory services.Findings include:Review of the facility policy titled Physician and other Communication/Change in Condition, revised 05/05/23, revealed, To improve communication between physicians and nursing staff to promote optimal patient/resident care, provide nursing staff with guidelines for making decisions regarding appropriate and timely notification of medical staff regarding changes in a patient's/resident's condition, and provide guidance for the notification of patients/residents and their responsible party regarding changes in condition. Procedures: 1. Complete assessment of the patient/resident which may include but is not limited to: . E. Blood Glucose . 3. Notify the physician of the change in medical condition. The nurse will document all assessments and changes in the patient's/resident's condition in the medical record.Review of the facility policy titled Laboratory Testing, revised on 05/05/23, revealed, . 2. The attending physician or physician extender shall be promptly notified of abnormal, critical, or stat [immediately] test results. 3. The charge nurse receiving the test results shall be responsible for notifying the physician or physician extender of such test results in a timely manner.Review of the facility policy titled Medication Management Program, revised on 01/15/25, revealed, . 3. Prior to administering medications, the nurse is responsible for: A. Obtaining and recording any necessary vital signs . 5. The authorized staff member validates the following information is documented on the MAR [Medication Administration Record]: A. Correct physician's order and diagnosis for each medication . 13. The authorized staff member administers medications according to accepted standards of practice and incompliance with regulatory requirements.Review of R87's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/04/25, located in the Resident Assessment Instrument (RAI) tab of the electronic medication record (EMR), revealed an admission date of 01/18/21 and a Brief Interview for Mental Status (BIMS) score of 5 out of 15, indicating R87's cognition was severely impaired and had a diagnosis to include but not limited to diabetes mellitus.Review of R87's Orders located in the EMR under the RAI tab revealed the following order: Lantus Solostar U-100 Insulin (insulin glargine) insulin pen; 100 unit/mL [millilitre] (3 mL); amt [amount]: 16 units; subcutaneous Special Instructions: Hold if fsbs [finger stick blood sugar] < [less than] 100 Every 12 Hours 08:00 AM, 08:00 PM, dated 07/10/25. Notify provider if less than 60 or greater than 450. Once A Day 06:00 AM, originally ordered on 07/26/22.Review of R87's Care Plan revised on 08/04/25, located in the EMR under the RAI tab revealed, [R87] is at risk for Hyper/Hypoglycemia secondary to Diabetes. Interventions included Medication adjustment per provider order and Give meds [medications] per order, labs [laboratory] per order and report abnormals [sic] to MD [physician].Review of R87's Progress Note dated 07/10/25, located in the EMR under the Progress Note tab revealed NP [Nurse Practitioner] increased resident's Lantus to 16u [unit] from 14u because of elevated A1C (a blood test that measures a person's average BS levels over the past 2-3 months).Review of R87's Progress Note dated 08/13/25, located in the EMR under the Progress Note tab revealed bg [blood glucose] low, snack x2 given.Review of R87's August 2025 Medication Administration Report (MAR) located in the EMR under the Order tab revealed at 6:00 AM, nine blood sugar (BS) levels were documented to be below 100 mg/dl and on one occasion no BS was documented. Insulin was documented as administered at 8:00 AM on these days. No BS was recorded for the PM insulin administration. Furthermore, BS levels below 60 included no documentation the physician was notified. These included:On 08/02/15 at 6:00 AM at 62 mg/dl,On 08/05/25 at 6:00 AM at 76 mg/dl,On 08/06/25 at 6:00 AM at 63 mg/dl,On 08/07/25 at 6:00 AM at 61 mg/dl,On 08/08/25 at 6:00 AM at 67 mg/dl,On 08/09/25 at 6:00 AM at 56 mg/dl,On 08/10/25 at 6:00 AM no BS was recorded,On 08/11/25 at 6:00 AM at 78 mg/dl,On 08/12/25 at 6:00 AM at 69 mg/dl,On 08/13/25 at 6:00 AM at 49 mg/dl.During an interview on 08/13/25 at 2:06 PM, Regulatory Specialist (RS) was asked if R87's insulin was administered when her BS was documented below 100, when her order instructed the nurse to not administer the insulin if her BS was below 100. RS was also asked why the BS was blank for 08/10/25 but insulin was documented as given. At 3:48 PM the RS stated she didn't find anything more than what was reviewed earlier for R87.During a telephone interview on 08/13/25 at 5:10 PM, the Clinical Pharmacist (CPh) was asked about R87's insulin being administered without a BS check in the PM when the insulin was administered twice daily, in the AM and PM. The CPh stated, It's best practice to match dosing schedule with the sticks.During an interview on 08/13/25 at 5:45

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure the physician documented that the Clinical Pharmacist (CPh) recommendations regarding the use of a PRN (as needed) medications were reviewed and failed to document the action taken or not taken to address the irregularities for one (Resident (R)13) of five residents reviewed from a sample of 43 residents. This failure had the potential to lead to unwarranted medication side effects or improperly treated symptoms.Findings include:Review of the facility policy titled Pharmacy Services Policies and Procedures dated 04/17/24 revealed, The facility will ensure that each resident's entire drug/medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, psychological wellbeing. The Facility will comply with all Federal, State and Local regulations regarding unnecessary drugs . 6. For non-Urgent recommendations, the Facility and Attending Physician must address the recommendation(s) in a timely manner that meets the needs of the resident. Upon receipt of the written Consultant Pharmacist Report of non-urgent recommendations, the DON or facility designee shall provide the report to the attending physician(s) or their designee during their next regularly schedule facility visit or within 5 business days, whichever should come first . 9. If the Attending Physician or their agent fails to address a recommendation or document a rationale for declining a recommendation: A. The Director of Nursing or facility designee will alert the Medical Director where MRR's [Medication Regimen Review] are not addressed timely or completely by the attending physician. Review of R13's Resident Face Sheet located under the Profile tab of the electronic medical record (EMR) revealed R13 was admitted to the facility on [DATE] with diagnosis including but not limited to anxiety. Review of R13's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/11/25 and located under the MDS tab of the EMR revealed R13 had severe cognitive impairment as assessed by staff. Review of R13's Orders located under the Orders tab of the EMR revealed a Prescription Order dated 06/17/25 for lorazepam (antianxiety medication) 1 milligram (mg) every 6 hours as needed with the End Date on the Prescription Order indicated Open Ended; an order for buspirone (antianxiety medication) 7.5 mg three times a day dated 06/10/22 with an End Date of Open Ended; and Lexapro (escitalopram) (antidepressant medication) 10 mg three tablets once a day dated 12/18/24 (renewal date) and an End Date of Open Ended. Review of R13's Note to Attending Physician/Prescriber signed by the facility's nurse practitioner (NP) on 07/24/25 revealed the CPh had recommended, Resident has a PRN order for an anxiolytic, lorazepam 1 mg Q6H (every 6 hours) which has been in place for greater than the 14-day observation period without a projected stop date or duration of therapy . Please consider discontinuing the PRN order or if the medication cannot be discontinued at this time, CMS requires that the prescriber document the indication for use, the intended duration of therapy and the rationale for the extended time period. On the Note to Attending Physician/Prescriber the NP response read, No longer on board. Review of R13's Note to Attending Physician/Prescriber dated 08/27/24 revealed the CPh had recommended This resident is currently receiving antidepressant therapy with escitalopram 20 mg QD. This dose has been in place for some time, and a review of the resident chart does not reflect a worsening of depression. To reach the minimal effective dose, may I suggest an attempt at a dose reduction? The facility NP responded on 09/16/24 with Resident on hospice. All med [medication] changes made by them.Review of R13's Note to Attending Physician/Prescriber dated 08/27/24 revealed the CPh had recommended This resident is currently receiving antidepressant therapy with buspirone 7.5 mg TID. This dose has been in place for some time, and a review of the resident chart does not reflect a worsening of depression. To reach the minimal effective dose, may I suggest an attempt at a dose reduction? The facility NP responded on 09/10/24 with Resident on hospice. All med changes made by them.Review of R13's Resident Documents in the EMR revealed no other provider communication related to the CPh's recommendations. Review of R13's Progress Notes revealed no other provider communication related to the CPh's recommendations.Review of R13's hardcopy hospice provider notes in the facility hospice binder revealed no notes related to the CPh's recommendations.During an interview on 08/13/25 at 3:15 PM, the Director of Nursing (DON) stated the pharmacy recommendations are emailed to her and then forwards to the facility NP for review. For residents on hospice services, the hospice agency providers managed the medications and so should receive the pharmacy recommendations. During an interview on 08/13/25 at 4:20 PM, the Team Coordinator (TCAH) for the hospice agency stated their agency did not receive pharmacy recommendations from the facility for R13