STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425084	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manna Post Acute	716 E Cedar Rock St Pickens, SC 29671

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and facility policy review, the facility failed to date, label, and/or cover food products stored in the kitchen. This failure had the potential to create an environment for food-borne illnesses which could affect 122 of 124 residents who consume food prepared from the facility's kitchen.Findings include: Review of the facility's policy titled, Food Storage and Retention Guide, which indicated, . that at a minimum, all food shall be labeled with the item name and the date opened. Further: The dietary department is responsible for routinely reviewing these guides to ensure that all food items are used within safe storage timeframes and that expired, unlabeled, or compromised items are promptly removed from service. During an observation on 05/19/26 from 9:25 AM to 10:05 AM, with the Dietary Manager (DM), revealed the following: - The main refrigerator contained six slices of turkey in plastic wrap with no date label. - 24 hardboiled eggs in plastic wrap with no date label. - A rack of 24 pork ribs wrapped in plastic with no date label. - The main freezer storage room contained lima beans in two bags with no date label, and two 24-packs of hamburger rolls with no date labels. During an interview on 05/19/26 at 10:15 AM, the DM confirmed the above observations and stated that staff should date all refrigerated products once the food items were opened. The DM confirmed that staff should also date all frozen items once they were opened. The DM also stated that there was no schedule for checking all food for date labels or expired food.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure Resident (R)3's fingernails were kept clean and trimmed for 1 of 1 resident reviewed for activities of daily living out of 24 sampled residents. Findings include: Review of the facility policy titled, Fingernails/Toenails, Care of, with a revision date of 02/18 noted, . The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. General Guidelines: 1. Nail care includes daily cleaning and regular trimming. 2. Proper nail care can aid in the prevention of skin problems around the nail bed. 4. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. Documentation. The following information should be recorded in the resident's medical record: 1. The date and time that nail care was given. 2. The name and title of the individual(s) who administered the nail care. 6. If the resident refused the treatment, the reason(s) why and the intervention taken. 7. The signature and title of the person recording the date. Reporting: 1. Notify the supervisor if the resident refuses the care. 2. Report other information in accordance with facility policy and professional standards of practice. Review of the facility policy titled, Activities of Daily Living (ADLs), Supporting, with a revision date of 03/18 noted, . Residents will be provided with care, treatment and services to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive services necessary to maintain good nutrition, grooming and person and oral hygiene. Policy Interpretation and Implementation: 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (bathing, dressing, grooming and or oral care). Review of the admission Record, located under the Profile tab of the electronic medical record (EMR) revealed R3 was admitted to the facility on [DATE], with diagnoses including but not limited to neuralgia and neuritis. Review of R3's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/01/26, and located under the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 15 out 15, which indicated intact cognition. The MDS further indicated R3 had upper extremity impairment on one side, and the resident required supervision or touching assistance for personal hygiene. Review of R3's Care Plan, with a review date of 06/12/24, and located under the Care Plan tab of the EMR revealed R3 required assistance from supervision to touching assistance with activities for daily living (ADLs) and required assistance with morning (AM) and evening (PM) care that included personal hygiene as needed. Review of R3's Progress Notes, located under the Progress Notes tab of the EMR reveled from 04/21/26 through 05/21/26, R3 did not refuse any care. Review of R3's Hygiene, located under the Task tab of the EMR revealed from 04/22/26 through 05/21/26, R3 did not refuse care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 05/19/26 at 2:16 PM, R3 revealed staff would not cut his fingernails even when he asked. R3's fingernails were observed with a brown/red substance underneath them and were over one fourth inch long. During an observation on 05/21/26 at 9:39 AM, R3's fingernails were over one fourth inch long and dirty with a brown/red substance underneath them. During an interview and observation on 05/21/26 at 1:04 PM, Certified Nursing Assistant (CNA)1, at R3's bedside, confirmed the resident's fingernails were approximately one fourth inch long, dirty with a brown substance underneath them. She confirmed they should be clean and trimmed. During an interview and observation on 05/21/26 at 1:07 PM, Licensed Practical Nurse (LPN)1, at R3's bedside, confirmed the resident's fingernails were over one fourth inch, substance underneath was dark in color and might be food. She confirmed the resident's fingernails were supposed to be cleaned and trimmed every Sunday because that was nail care day and they should also be cleaned and trimmed as needed to reduce infection and for sanitary reasons.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure Resident (R)93, who was admitted to the facility with a contracture, was provided with the services to prevent further decrease in range of motion/mobility for 1 out of 2 residents reviewed for contractures out of a total sample of 24 residents.Findings include: Review of the facility policy titled, Resident Mobility and Range of Motion, revised on 07/17 noted, . 1. Residents will not experience an avoidable reduction in range of motion (ROM). 2. Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. Policy Interpretation and Implementation: . 6. Interventions may include therapies, the provision of necessary equipment, and/or exercise and will be based on professional standards or practice and be consistent with state laws and practice acts. Review of R93's admission Record, located under the Profile tab of the electronic medical record (EMR) revealed R93 was admitted to the facility on [DATE], with diagnoses including but not limited to contracture right hand and contracture left hand. Review of R93's quarterly Minimum Data Set (MDS), located under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 05/05/26, revealed a Brief Interview for Mental Status (BIMS) score of 0 out of 15, indicating severe cognitive impairment. The MDS also revealed R93 had upper extremity impairment on both sides. Review of R93's Order Summary Report, located under the Orders tab of the EMR revealed cushion carrots to bilateral hands every shift for contraction, start date 02/04/26. Review of R93's Care Plan, initiated on 02/05/26 and located under the Care Plan tab of the EMR revealed carrots to bilateral hands as ordered. Review of R93's Progress Notes, located under the Progress Notes tab of the EMR from 04/21/26 thought 05/21/26, did not indicate R93 had any behaviors or refusal of device. During an observation on 05/19/26 at 2:49 PM, R93 had a palm guard in the right contracted hand. The left hand was contracted with no device. During an observation on 05/20/26 at 9:51 AM, R93 had a palm guard in the right contracted hand, and no device in the left hand that was contracted. During an observation on 05/21/26 at 10:36 AM, R3 had no palm guard in the right contracted hand, and the left hand was contracted with no device. During an interview and observation on 05/21/26 at 1:13 PM, at R93's bedside, Licensed Practical Nurse (LPN)2, confirmed R93's hands were hard to open and that the resident should have a device placed in his palm to prevent further contracture. During an interview on 05/21/26 at 1:19 PM, the Director of Nursing (DON) confirmed R93 should have a device placed in his bilateral contracted hands.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to follow physician's order for oxygen administration and to have storage bags present in accordance with professional standards of practice, while administering oxygen to 2 residents (Resident (R)3 and R93) of 2 reviewed for respiratory care out of a total sample of 24 residents.Findings include: Review of the facility policy titled, Oxygen Administration, with a revision date of 10/18 noted, . The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation: 1. Verify that there is a physician's order for the procedure. Review the physician's order for oxygen administration. 1. Review of R3's admission Record, located under the Profile tab of the electronic medical record (EMR) revealed R3 was admitted to the facility on [DATE], with diagnoses including but not limited to respiratory failure with hypercapnia, chronic pulmonary edema, bronchitis, seasonal allergies, and chronic obstructive pulmonary disease (COPD). Review of R3's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/01/26, and located under the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. The MDS also indicated R3 received oxygen therapy. Review of R3's Order Summary Report, located under the Orders tab of the EMR revealed oxygen at four liters per minute (LPM) through nasal cannula, start date 06/09/24. Review of R3's Care Plan, revised on 04/12/26 and located under the Care Plan tab of the EMR revealed respiratory/oxygen use: Resident is at risk for respiratory complications related to chronic bronchitis, COPD, seasonal allergies, and chronic pulmonary edema. Oxygen as ordered. During an observation on 05/19/26 at 2:12 PM, R3 was in his room receiving oxygen through nasal cannula at three LPM with no storage bag present. During an observation on 05/21/26 at 9:54 AM, R3 was receiving oxygen through nasal cannula at three and a half LPM with no storage bag present. During an interview and observation on 05/21/26 at 1:07 PM, at R3' bedside, Licensed Practical Nurse (LPN)1 confirmed R3 was receiving three and a half liters of oxygen. LPN1 confirmed the physicians order was for four liters of oxygen. LPN1 confirmed there was no storage bag present and since R3 goes outside to smoke a storage bag would be needed to keep the resident's oxygen tubing from becoming dirty. 2. Review of R93's admission Record, located under the Profile tab of the EMR revealed R93 was admitted on [DATE], with a diagnosis including but not limited to acute respiratory failure with hypoxia. Review of R93's quarterly MDS, with an ARD of 05/05/26 and located under the MDS tab of the EMR, revealed R93 had a BIMS score of 00 out of 15, indicating severe cognitive impairment. The MDS also indicated R93 received oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R93's Order Summary Report, located under the Orders tab of the EMR revealed oxygen at five liters through nasal cannula every shift to keep oxygen above 90, start date 09/18/24. Review of R93's Care Plan, revised on 12/15/25 and located under the Care Plan tab of the EMR revealed respiratory/oxygen use: Resident is at risk for respiratory complications related to history of acute respiratory failure with hypoxia and recent pneumonia. Administer oxygen as ordered. During an observation on 05/19/26 at 3:17 PM, R93 was in his room receiving oxygen through nasal cannula at three and a half LPM with no storage bag present. During an observation on 05/20/26 9:51 AM, R93 was in his room receiving oxygen through nasal cannula at three LPM with no storage bag present. During an interview and observation on 05/21/26 at 1:03 PM, at R93's bedside, LPN2 confirmed R93 was receiving four and a half liters of oxygen. LPN2 confirmed the physician order was for five liters of oxygen. LPN2 confirmed there was no storage bag present. During an interview on 05/21/26 at 1:03 PM, the Director of Nursing (DON) confirmed physician orders for oxygen should be followed and that storage bags should be present.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to obtain a physician's order for isolation. Additionally, the facility did not ensure that appropriate isolation waste receptacles were available in the resident's room, and staff improperly disposed of isolation materials in the residents personal trash can for 1 of 1 resident, (Resident (R)28), reviewed for transmission based precautions out of a total of 24 sampled residents. These failures created a risk of contamination and increased the likelihood of transmitting infection to others. Findings include: Review of the facility policy titled, Isolation- Transmission- Based Precautions & Enhanced Barrier Precautions, with a revision date of 09/22 indicated, . Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to others. Policy Interpretation and Implementation: . 2. Transmission-based precautions are additional measures that protect staff, visitors, and other residents from becoming infected. These measures are determined by the specific pathogen and how it is spread from person to person.4. The facility makes every effort to use the least restrictive approach to managing individuals with potentially communicable infections. Transmission-based precautions are used only when the spread of infection cannot be reasonably prevented by less restrictive measures. Contact Precautions: 1. Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the resident's environment. 2. Contact precautions are also use in situations when a resident is experiencing wound drainage, fecal incontinence or diarrhea, or other discharges from the body that cannot be contained and suggest an increased potential for extensive environmental contamination and risk of transmission of a pathogen, even before a specific organisms has been identified. Review of R28's admission Record, located under the Profile tab of the electronic medical record (EMR) revealed R28 was admitted to the facility on [DATE], with a diagnosis including but not limited to extended spectrum beta lactamase (ESBL) resistance. Review of R28's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/01/26 and located under the MDS tab of the EMR, revealed R28 had a Brief Interview for Mental Status (BIMS) of 4 out of 15, indicating severe cognitive impairment and Multidrug-Resistant Organism (MDRO). Review of R28's Order Summary Report, dated 05/26 and located under the Orders tab of the EMR revealed R28 had no physicians order for transmission-based precautions. Review of R28's Care Plan, revised and reviewed on 05/08/26 and located under the Care Plan tab of the EMR revealed: . [The] resident is at risk for complications related to urinary tract infection (UTI). and contact precautions related to UTI/ESBL. During an observation on 05/19/26 at 3:32 PM, R28 was lying in bed receiving intravenous fluids and was on contact isolation. During an interview on 05/19/26 at 3:33 PM, Certified Nursing Assistant (CNA)2 verified R28 had ESBL in her urine and that R28 was on contact isolation. No separate trash cans (red or yellow) were (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	present in room for isolation materials to be disposed in. During an observation on 05/20/26 at 2:22 PM, R28 was in her room and had no separate trash cans for isolation personal protective equipment (PPE). During an observation on 05/21/26 at 10:41 AM, Resident 28 was in her room with no separate trash cans for contact isolation PPE. During an interview and observation on 05/21/26 at 1:03 PM, in R28's room, Licensed Practical Nurse (LPN)2 confirmed R28 only had a personal trash can in her room for PPE disposal. LPN2 was not sure if there should be separate waste receptacles for personal trash and isolation PPE/waste materials. LPN2 was unable to find a physician's order for transmission-based isolation. During an interview and observation on 05/21/26 at 1:19 PM, in R28's room, the Director of Nursing (DON) stated, We have never had that policy before. PPE goes in the personal trash can and should come out after each time. The DON then confirmed there was unremoved PPE in R28's personal trash can, that R28 was in her room, and no other staff were present in the room. The DON then said, There should've been an extra trash can or at least one by the door. The DON revealed there had been a physician's order for transmission-based isolation.