STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Manor - Spartanburg	375 Serpentine Drive Spartanburg, SC 29303

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46934 Based on review of the facility policy, record review, and interviews, the facility failed to notify the on-call provider regarding a significant change in a resident's (R)1 condition. Specifically, critical lab blood sugar readings were not communicated timely. Findings include: Review of the facility policy titled, Physician and Other Communication/Change in Condition dated [DATE], 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 patient/resident's condition, and provide guidance for the notification of patient's/residents and their responsible party regarding changes in condition. Section 3 of the policy states, 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. Changes and new approaches will be reflected in the individualized care plan. R1 was admitted to the facility on [DATE], with diagnoses including but not limited to; diffuse traumatic brain injury, type 2 diabetes mellitus without complications, seizures, and muscle weakness. A review of the Annual Minimum Data Set (MDS) with Assessment Reference Date (ARD) date of [DATE] revealed R1 had no Brief Interview of Mental Status (BIMS) documented, due to the resident being rarely/never understood. Review of the physician progress notes revealed a noted dated, [DATE] created by Family Nurse Practitioner, FNP, the resident was seen by him due to a new concern. Staff notified the provider of regard to the patient's condition. The nursing staff reported resident with seizure activity and lethargy. FNP noted, per nursing staff, the patient had been lethargic over the weekend and was noted with a brief seizure episode the morning of [DATE]. FNP visited the patient and made an assessment, FNP stated that the resident does not appear to be in any distress. FNP ordered labs to check therapeutic levels of Keppra and check CBC with diff, BMP, and UA with culture and sensitivity. Additional record review revealed a progress noted dated [DATE] at 03:34 PM, Labs ordered for morning, POA aware. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An additional progress note dated [DATE] at 06:47 PM CLS Lab called this nurse to inform of critical lab value on glucose, with it being over 500 at the time of blood draw, early this morning. This nurse immediately checked the resident's blood sugar with a reading of 201. Will continue to monitor throughout the shift; the patient is currently only on oral diabetic meds. Will place on MD list for morning for possible need of frequent blood sugar checks and possible sliding scale needs. POA aware. A progress note dated [DATE] at 09:03 AM: SW was notified by DON that the resident passed away at the hospital. A review of R1's vital signs in the medical record regarding blood sugar checks revealed there was no blood sugar results documented. Furthermore, there was no documentation on R 1's EMR that the provider was notified of R1's critical blood sugar level. A review of R1's care plan revealed that Resident is diabetic, and is at risk for elevated blood sugars, low blood sugars, and changes in mental status. Interventions associated with the care plan are as follows: FSBS as needed, report abnormal to MD. if indicated, Document changes in mental status., notify MD. diet as ordered. monitor for thirst, excessive appetite or voiding, change in LOC, mood, perspiring--report to MD. give meds per order for DM. Report abnormal labs to MD. An interview with Licensed Practical Nurse, (LPN)1 on [DATE] at 12:00 PM revealed that she does not particularly remember the incident in regard to R1's decline. LPN1 stated that if she was taking care of a resident with blood sugars outside of normal limits (500), she would re-draw the sugar and report it to the Provider, especially if the resident is experiencing any changes in condition. LPN1 stated that for residents who have a blood sugar of 200, the abnormal reading does not warrant an immediate report to the provider on call. LPN1 stated they typically just write down the findings in the M.D (Medical Doctor) rounding book so the patient can be seen the following day by the provider during rounds. An interview with the facility's FNP on [DATE] at 12:33 PM revealed that FNP was notified of the changes in the resident's condition as far as the resident's frequency of seizures. FNP revealed that he placed orders for the labs to be drawn on [DATE]. FNP revealed that he was not notified of the resident's abnormal labs when CLS called the facility to report the critical lab value on [DATE] at 1711 (5:11 PM) hours. FNP revealed that it is his expectation of staff members to report abnormal findings to him immediately, especially if the resident is having a significant change in status. FNP stated, I have been employed at at this facility for years now and a vast majority of the staff have his phone number and that he has built a good enough rapport with staff that they can call him at any time of the day. FNP stated that if he had been notified of the abnormal lab values, he would have closely looked at the results and made some interventions. FNP stated that he was not made aware of the R1's labs until after the resident had already expired. An interview with the Director of Nursing, (DON) on [DATE] at 1:10 PM revealed that it is her expectation of staff to report any abnormal labs to the provider especially if the resident is exhibiting any changes in condition. DON revealed that typically Providers are reliant on facility staff members in regards to receiving any results of lab draw results after hours. DON stated that if any abnormal findings in regard to resident lab draws are not reported to the Provider, it would be hard for providers to provide further guidance or orders in regard to interventions to resident care. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN2, on [DATE] at 2:57 PM revealed that the providers are easily accessible during and after hours. LPN2 states that providers for the facility typically have very quick response times. LPN2 states that providers expect her and other nursing staff in the facility to report any major changes in regards to the resident condition and or any irregularities in labs, imaging studies, vital signs, etc as soon as possible. LPN2 stated she remembers receiving the resident's abnormal lab value from CLS and states she reported the blood sugar reading to the on-call provider. LPN2 states on call provider told her to monitor the resident blood sugars often to report any blood sugars above 250 and to just closely monitor the resident. LPN2 states she remembers taking the resident blood at least every hour for the rest of her shift. LPN2 states that the blood sugar checks during that time ranged between 190 and 210. LPN2 could not produce any documentation that reflects the statement she has made in regard to the resident's blood sugar checks, nor was she able to present any documentation in regard to the interaction she had with the provider indicating that she informed the on-call provider and received an order to check blood sugars often and to report any abnormal findings. LPN2 does not remember why these interactions, blood sugars, and orders were not documented as she states she is typically one to write, novels in regard to her documentation. LPN2 states that she passed off the instruction regarding frequent BS checks and monitoring to the 3rd Shift, LPN3. An interview with the On-call provider service center was attempted on [DATE] at approximately 3:30 PM to verify any communication made between the facility and on-call provider on [DATE] after 5:00 PM to corroborate LPN's recollection of notifying the provider of the resident's abnormal blood sugar reading. The call was unsuccessful, after 25 minute hold. An interview with the Facility Administrator, (FA) on [DATE] at 3:58 PM revealed that it is the Administrator's expectation of staff to report any major changes in regards to resident condition, abnormal labs, imaging studies, etc, to the provider. FA stated that after hours, she expects staff to report any significant changes to the on-call provider and to document any interaction, conversation, or orders staff may have received during the conversation. In this particular case, the FA stated that the LPN should have recorded the orders she received from the physician, as well as the blood sugars LPN2 drew during the shift. FA stated she understands the practice that if something is not charted, it is hard to prove that any aforementioned actions were completed by staff. Attempts were made to interview R1's Representative via telephone on [DATE] at 11:33 AM, 03:52 PM, and 3:55 PM. All three attempts were unsuccessful. An attempt was made to interview LPN3 via telephone on [DATE] at 03:25 PM. A voicemail was left for a return phone call.