

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 11/26/2024
NAME OF PROVIDER OR SUPPLIER Magnolia Manor - Spartanburg		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48835</p> <p>Based on review of facility policy, observation, interview and record review, the facility failed to report an allegation of physical abuse, involving Resident (R)2, within the required timeframe, for 1 of 4 residents reviewed for abuse.</p> <p>Findings include:</p> <p>Review of the facility policy titled, Abuse, Neglect, Exploitation, or Mistreatment revised on 10/23/19, documents, The facility's Leadership prohibits neglect, mental, physical, and or verbal abuse . and ensures that alleged violations involving abuse, neglect, exploitation or mistreatment . are reported immediately.</p> <p>Review of R2's Face Sheet revealed R2 was admitted to the facility on [DATE], with diagnoses including but not limited to: chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, unspecified depression and cerebrovascular accident.</p> <p>Review of R2's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 09/02/24, revealed R2 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating R2 had moderate impaired cognition.</p> <p>Review of R2's Progress Note dated 09/10/24 at 2:17 PM, written by the Social Worker revealed, Spoke with resident related to allegations of physical abuse from a certified nurses assistant. Resident laying in bed, alert and pleasant at time of conversation. Resident informed SW of his abuse allegation and stated he would not remember the exact day but was able to state the alleged abuse occurred this past weekend and named the staff member.</p> <p>Review of Licensed Practical Nurse (LPN)1's Suspension Pending Investigation dated 09/11/24, revealed LPN1 was suspended pending investigation for, Failure to report an allegation of abuse per policy.</p> <p>Review of Certified Nursing Assistant (CNA)1's Corrective Action Form dated 09/17/24, documented a performance/behavioral as, Discharge, for, Violation of policy for failure to report combative resident incident to supervising nurse and failure to cooperate in an investigation.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of LPN1's Corrective Action Form dated 09/17/24, indicated a performance/behavioral as, Final Warning . Employee did not follow facility policy for reporting an allegation . Employee is expected to notify the administrator-who is the facility abuse coordinator, and or Director of Nurses (DON) at the time of any suspected or reported suspicion of abuse or neglect so that proper actions can be taken and a thorough investigation initiated to ensure the safety of residents.</p> <p>During an interview on 11/26/24 at 10:47 AM, LPN2 stated, [R2] just kept calling my name one day. I went into his room and asked him what he needed. He said something like, someone had hit him, she hit me. I asked who, he said, [CNA1]. I don't know her, she worked weekends. He said she was mean to him. I went to tell my DON and Administrator. He told her the same thing. She had hit him on his left side.</p> <p>During an interview on 11/26/2024 at 12:11 PM with LPN1. She stated, I am aware of reporting any allegations of abuse. I would immediately report to my DON/Administrator. I think it was Sunday. It never came up again until Tuesday. I was asked to come in or speak to an officer. She placed me on suspension over the phone until it was figured out. I didn't see any marks on him. I never asked him directly if anyone had hit him.</p> <p>During an interview on 11/26/24 at 12:58 PM, the DON stated, It was over the weekend that it occurred, not sure if it was the 7th or the 8th of September. It was reported to us on 09/10/24 and we started an investigation. [R2] alleged [CNA1] slapped him on the side of his face and verbal remarks of hanging him from a tree. [LPN1] was the nurse on that weekend. She should have reported that to us, administration, immediately. We suspended her for that. We reported it after we found out.</p> <p>During an interview on 11/26/24 at 1:50 PM, the Administrator stated, I am the abuse coordinator. I reported it when I was notified. He said someone had hit him. I called the cops and completed a body audit. The staff are supposed to call me immediately. [LPN2] let me know that day when she was notified. After we started our investigation, we found out that this was reported to staff over the weekend.</p>		