STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425091	A. Building B. Wing	03/04/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48835 Based on review of facility policy, record review and interview, the facility failed to notify the provider of a dehisced wound for 2 days, which caused Resident (R)8 to return to the hospital, for 1 of 1 residents reviewed. Findings include: Review of the facility policy dated 06/01/15, titled, Surgical Incisions documents, The clinician will follow specific physicians orders for treatment of these wounds. Obtain clarification orders if the initial orders are not specific. These wounds are usually covered with dry dressings. Based on review of facility policy, record review and interview, the facility failed to notify the provider of a dehisced wound for 2 days, which caused Resident (R)8 to return to the hospital, for 1 of 1 resident reviewed. Findings include: Review of the facility policy dated 06/01/15, titled, Surgical Incisions documents, The clinician will follow specific physician's orders for treatment of these wounds. Obtain clarification orders if the initial orders are not specific. These wounds are usually covered with dry dressings. Review of R8's Face Sheet revealed he was admitted to the facility on [DATE], with diagnoses including but not limited to acquired absence of right leg above knee (AKA), peripheral vascular angioplasty status with implants and grafts, Type 2 diabetes mellitus with diabetic neuropathy and phantom limb syndrome with pain. Additionally, it recorded a last qualifying hospital stay dated 12/30/24 - 01/06/25. Review of R8's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/17/24, revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating he was cognitively intact. Review of progress noted dated 12/28/24 at 06:19 PM revealed, R8 in bed, incision to right AKA open draining blood, pain to touch. Reported findings to Director of Nursing, (DON) and placed in Medical Doctor (MD) for assessment. Area cleanse with wound cleanser with calcium alginate and a foam dressing until being assessed by Nurse Practitioner (NP). (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an additional progress note dated 12/30/24 at 09:55 AM of R8 revealed, Received order from facility NP to send patient to emergency room (ER) for eval of the right AKA as it is draining large amount of copious greenish bloody drainage. Record Review of hospital records dated 12/30/2024-12/31/2024 Hospital Day 1, recorded, Assessment/Plan: Principal Problem: Wound Dehiscence, Active Problems: Wound Infection, Physical Exam: Extremities: Right AKA dehiscence of the wound and drainage. X- Ray Femur Impression: status post recent AKA. Little soft tissue material appears to cap the tip of the femoral osteotomy, correlate for wound breakdown clinically. During an interview on 03/03/25 at 2:41 PM with Licensed Practical Nurse (LPN)12 revealed, The Certified Nurse Assistant (CNA) had been telling the nurses that R8 had an open wound, his amputation site. I knew about because I went to lunch. Another nurse came to my cart and told me a CNA reported that the resident he had an open wound on his surgical site, there was no dressing. I was on lunch. I told her I'm taking my break. I gave pain medication; he was in a lot of pain. He was probably at an 8. I called the DON; she was not aware of it. I facetimed the DON. She told me what dressing to put on it. She told me she was going to take care of the order. I don't think I called the NP or the MD. It was very pink, a mod amt of blood. It was not purulent at that time. I did not notify his family. I asked if I needed to do an incident report, she said no. During a telephone interview on 03/03/25 at 3:27 PM with the treatment nurse revealed, I did remove his staples, he handled it well. I believe his wound dehisced over the weekend. He was sent out. I wasn't there. A nurse came to me on the Friday before, it was draining a little on the right lateral side. After the staples, I left it open to air. She asked me to look at it. It was still closed then. I wrapped it. It wasn't draining after I looked at it. During an interview on 03/03/25 at 2:06 PM with LPN13 revealed, R8 came back with the AKA. The wound nurse removed the staples. Towards the end of the week, it was bleeding a little. I told the wound nurse about it. She did not apply steri-strips initially after the sutures were removed. She did apply steri-strip, at the end of the incision where it started bleeding, it was not open, that was Friday. It held through the weekend into the following week. Towards the middle of the following week, there was still 1 steri-strip on there. That Friday the 27th, I left the one steri-strip, and it looked fine. A CNA text me, over the weekend, on Saturday the 28th. She told me his leg was draining, she said it looks infected and open, and I told her to tell his nurse. She said the nurse had an attitude. I told her I am off today, and I'll look at it on Monday. The CNA wrote that she asked the nurse for a patch to put over it and she said she can't do it right now. I told her fine, I was just making sure I let you know. I did not call anyone to report this. I mentioned the text to my DON and UM when they questioned me. It does concern me that he was bleeding from the wound, and he was on Eliquis. I saw the wound when I returned. It was the first thing I did. There was an improper dressing with an ABD pad wrapped with tape around his stump. I don't remember a date. I removed the dressing, the wound was dehisced, about 2 inches, from the end where I noted it the previous Friday. The drainage was brown and yellow. I called NP immediately. He came to come and look at it and made the decision to send him out to the hospital. He was concerned as why it wasn't addressed over the weekend. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/03/25 at 2:33 PM with CNA14 revealed, I went into the room to do R8's hygiene. We had an agency nurse. I told her his right wound was open and bleeding. It was like fresh, new blood. The steri-strips were hanging off a bit. I went back to go and check on him, and she hadn't done anything yet. I went and got another nurse who works every weekend. She spoke to the agency nurse. During a telephone interview on 03/03/25 at 4:30 PM with LPN15 revealed, I only worked on Saturday and Sunday. I addressed R8 with the nurse on duty. I never actually did the dressing change. The wound had dehisced, it was a surgical incision. The CNA came and got me, I looked at it. I went to the nurse on the floor. I said to her you can send him out or put a wet to dry dressing on it and wait for the doctor until Monday. During an interview on 03/03/25 at 3:39 PM with the Nurse Practitioner (NP) revealed, R8 had a wound that dehisced. I was asked to see him. It looked infected to me; it was more than we were capable of. He was probably going septic, and he need Intravenous (IV) antibiotics (ABT). The weekend staff should have called the on-call provider. The NP confirmed it was the Monday after the wound dehisced that he observed the wound. During an interview on 03/03/25 at 5:20 PM with the Clinical Services Director (CSD) revealed, They did not have any orders for monitoring of R8's surgical wound when he returned from the hospital, only his abdominal wound, not the right AKA. He should have had orders to monitor his surgical amputation site. The CSD confirmed there were no orders in R8's medical record relating to the right AKA. During an interview on 03/04/25 at 10:20 AM with the DON confirmed R8's dehiscent wound. She stated, I can't recall completing education on dehiscent wounds. For a new amputation, the site should be monitored. If orders were not received by the hospital, contact the NP or surgeon for orders.

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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** 48835 Based on review of the facility policy, observation, record review and interview, the facility failed to ensure ordered fall devices were in place for 1 Resident (R)11, reviewed for accidents. Findings include Review of the facility policy titled, Fall Management with a revision date of May 5, 2023 revealed under the policy, The facility will identify each resident who is at risk for falls and will plan care and implement interventions to manage falls. The facility provides assistive devices based onindividual resident needsto facilitate mobility and prevent falls. Record review of R11's facesheet revealed he was admitted to the facility on [DATE] with diagnoses that include but are not limited to; displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Record review of R11's Quarterly Minimum Data Set (MDS) with an Assesment Reference Date (ARD) of 12/02/24 revealed he had a Brief Interview Mental Status (BIMS) score of 13 out of 15, indicating he was cognitively intact. During an observation and interview on 03/03/25 at 10:00 AM, R11 was observed lying in bed. R11 stated, The lights went off. I got up to turn the lights back on. I started walking and I fell backwards. He pointed to his right leg, and said, This is the leg I fractured. Additional observation revealed there were no non-skid strips at his bedside. There were no anti-roll back on his wheelchair (W/C). His wheelchair was locked at his bedside, directly by his bed toward the foot of the bed. Record review of R11's progress notes dated 11/25/24 at 01:48 AM revealed On arrival R11 was observed on the floor at the foot of B bed. Resident stated that he was going to the bathroom and his wheelchair slipped backward. Wheelchair was found in the locked position on both sides. On assessment of resident, he was able to move both arms but unable to move right leg due to pain in right hip. On-call provider, notified. Order received to send resident to Emergency Department (ED) for evaluation. Message left for Director of Nurses. (DON). 911 called and resident was transported to ED. Record review of R11's progress noted dated 12/16/24 at 10:58 AM revealed, Received order for [NAME] to be applied to w/c for use at all times. [NAME] has be applied. Patient is aware. Record review of R11's physician orders revealed on 11/26/24, an order for Anti-roll back device to wheelchair. Additionally, on 12/07/24 an order for Nonskid strips to floor by bed. There was not an order for a Dycem. Record review of R11's care plan with a revision date of 01/21/25 for falls revealed an approach to, apply dycem to W/C as ordered. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/03/25 at 2:55 PM, an interview with Certified Nursing Assistant (CNA)15 revealed, I'm not sure he is a fall risk. Most times the wheelchair is by the bed. He gets up on his own, but we ask him to please call staff to observed just in case. I helped him this morning. He got in his W/C. She pointed to his W/C, it did not have the anti-rollbacks. CNA15 said she was not aware of his safety measures. She said, We could check the computer. She said she's not aware if it would be there. She clicked on resident profile, and it did show the anti-rollbacks to his W/C and the non skid strips at bedside. She said, I didn't know I could see this. On 03/03/25 at 3:05 PM, an interview with Licensed Practical Nurse (LPN)13 revealed, R11 has anti rollbacks to his W/C because he is a fall risk. She said she did not realize his W/C did not have antiroll backs. She walked down to R11's room to observe the W/C at R11's bedside and said, The W/C may have got mixed up with his roommates W/C. On 03/04/25 at 10:00 AM, an observation revealed LPN13 was in the room with R11. He had the correct W/C at bedside with the anti-rollbacks. LPN13 stated, They had the W/C's mixed up yesterday and I also went back to review his orders. He was supposed to have the anti-skid strips on the floor. They got them put down; it was my fault for not checking. The anti-skid strips were observed at R11's bedside on the floor. On 03/04/25 at 10:20 AM, an interview with the DON revealed, For falls, all ordered safety measures should be in place for any resident.