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 06/14/2024

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 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46934 Based on a review of the facility policy, record reviews, and interviews, the facility failed to ensure a resident had a safe and orderly discharge from the facility, for 1 of 1 resident. Specifically, Resident (R)60 was transported and discharged from the facility on 06/12/24 to the [NAME] Housing Authority, 62 miles from the facility. The [NAME] Housing Authority was not able to receive R60 due to financial issues. Furthermore, the facility failed to obtain a physician order for the discharge. On 06/13/24 at 7:19 PM, the Administrator and the Director of Nursing (DON) were notified that the failure to ensure a resident had a safe and orderly discharge from the facility constituted Immediate Jeopardy (IJ) at F624. On 06/13/24 at 7:30 PM, the survey team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template and informed the facility IJ existed as of 06/12/24. The IJ was related to 42 CFR 483. 15 - Admission, Transfer, and Discharge. On 06/14/24 at 8:57 AM, the facility provided an acceptable IJ Removal Plan. On 06/14/24 at approximately 10:00 AM, the survey team validated the facility's corrective actions and removed the IJ. The facility remained out of compliance at F624 at a lower scope and severity of D. Findings include: Review of the facility policy titled Discharge/Transfer with a complete revision date of 11/01/2017 states, The patient/ resident will be discharged /transferred (home/another entity) by order of his/her attending physician. The facility will include the patient/resident and family in developing a safe discharge plan to address the patient's/ resident's individual needs. Procedures: 1. Obtain a discharge order from the physician. 2. Notify the patient/resident, his/her legal representative, if any, or an interested family member and document the discharge. Types of discharges: Planned discharge to the patient's/resident's home/private residence. Obtain an order for discharge/transfer from the patient's/resident's physician. Arrange community resources identified by the interdisciplinary team/patient/resident and/or family. Provide written Discharge Instructions for care to the patient/resident and/or family when discharging the patient home or to a community setting such as assisted living. Complete the Discharge Summary, documenting the patient's/resident's assessment at time of discharge and a summation of the patient's/resident's stay. Place a copy of the completed forms in the patient's/resident's medical record. Refer to Social Services Policy on Discharge Planning. (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

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 06/14/2024
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F 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R60's Face Sheet revealed that R60 was admitted to the facility on [DATE], with diagnoses including but not limited to: Schizophrenia, chronic obstructive pulmonary disease, moderate persistent asthma, hyperlipidemia, Type 2 diabetes mellitus without complications, shortness of breath, and acute on chronic systolic (congestive) heart failure. Review of R60's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/18/24, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R60 was cognitively intact. Review of R60's Decisional Capacity Form dated 05/31/24, revealed R60 does not meet all the criteria for decisional capacity and therefore cannot make healthcare decisions for himself. Review of R60's Discharge Summary dated 06/12/24 revealed, This resident is being seen today for discharge assessment and is set to discharge from this facility later today, this patient will be going home with family care later today. The Discharge Summary further revealed, R60 was discharged to Section Housing through [NAME] Housing Authority on 06/12/24 and R60 signed his own discharge. Review of R60's Physician Orders revealed an order dated 04/12/24 which stated, I certify that this resident requires continuing placement in a long term care facility. Further review of R60's Physician Orders revealed there was no order for R60's discharge. Review of R60's Care Plan dated 04/16/24 revealed the following: Problem: R60 has discharge potential to a less restrictive environment. A safe discharge plan will be developed to allow him/her to return to the community or less restrictive or alternate environment. R60's stated discharge goal is to return home to [NAME]. R60 is working with [NAME] Housing Authority on alternate residences. Problem: R60 has schizophrenia. Problem: R60 has the risk of respiratory issues related to congestive heart failure, asthma, COPD. He has trouble with SOB when lying flat at times. Problem: R60 appears to have a recall deficit as evidenced by: : [ ] Short-term recall, [ ] Long-term memory recall, [ ]inability to understand commands/communication [ ]Poor decision-making Related to the diagnosis of: [ ]Intellectual Disability, [ ]Dementia, [ ]Traumatic Brain Injury, [ ]Parkinson's Disease, [ ]Late effect of CVA, Others: schizophrenia with periods of inattentiveness and disorganized thinking. Review of R60's Progress Notes revealed the following: 06/12/2024 11:26 AM [Recorded as Late Entry on 06/13/2024 11:26 AM] Resident discharged from facility via Ambustar transport. All discharge paperwork, medications, Rx and belongings sent with resident. 06/07/2024 11:11 AM SW called and left message with resident's sister, informing her of resident's dc plans and requesting a return call with any questions. SW will continue to observe and assist PRN. 06/07/2024 10:55 AM SW spoke with resident's CLTC caseworker via phone and informed her that resident will be discharging next week. She stated she did not need a new referral since resident's case was still open. [CLTC caseworker] stated she only needs resident's discharge date and new address. SW emailed this information to caseworker per her request. SW will continue to observe and assist PRN. (continued on next page)

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F 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/13/24 at 1:42 PM, R60 stated, When I got to the house yesterday, they were requesting a deposit, which I didn't have. No one told me I needed a $900.00 deposit. Transport dropped me off and left. I slept in a motel last night. I'm talking to you on the phone and I'm walking, trying to find a place to stay. I'm hot. My sister lives in New Jersey, I don't think she knows I left. During an interview on 06/13/24 at 2:16 PM, Social Services (SS) confirmed she knew the resident and assisted him with his discharge. SS stated that R60 requested to be discharged because he was ready to go. SS stated that the resident's family members were contacted on April 2024 shortly after admission and they agreed and requested [NAME] SC. SS stated she spoke with a cousin, who contacted the housing authority on 05/06/24. No NOMNC was issued because the resident was only on Medicaid. SS stated Housing Authority set up water and electricity provided by [NAME] (Housing Authority Representative). SS stated she called the resident's sister related to the discharge and left a voicemail, no actual conversation. SS stated she was not aware that the resident did not have a decisional capacity to make his own decisions. SS stated that R60 is not his own responsible party. SS stated I was going off his BIMS and it's a 15. An attempt to interview the Ombudsman on 06/13/24 at 2:52 PM, was unsuccessful, a voicemail was left for a return call. An attempt to interview the Medical Doctor on 06/13/24 at 3:02 PM, was unsuccessful, a voicemail was left for a return phone call. During an interview on 06/13/24 at 3:27 PM, the Housing Authority Representative ([NAME]) confirmed housing plans were made with the facility social worker and the resident. The resident's appointment was not on 06/12/24, so he was not to report there. His appointment was today 06/13/24 at 2:00 PM. They are currently working on the resident's housing, but he will be staying in a motel until housing is available. The [NAME] stated she did not call the facility today to report that housing fell through. The [NAME] states she cannot provide any more information due to the Privacy Act. During an interview on 06/13/24 at 3:48 PM, the Ambustar Transport Driver (TD) stated, I took him [R60] to downtown [NAME] SC, it was an old building. I do not know the exact building. Once I came to the city limits, the resident took over with directions and said there it is. The facility did not give me a form with the address, they didn't give me anything, just his belongings. We have an app we use, with an address for him. He didn't have any equipment. He walked fine and carried a few bags. When we arrived, [R60] stated, This is it and he never opened the front door. He said, I got it, and everything is fine. I took everything out of the van and the resident requested me to put his belongings on the porch. He didn't knock on the door or ring the doorbell. He was just standing there, it looked like he was walking towards the diner across the street. He looked like he knew what he was doing, so I left. During an interview on 06/13/24 at 5:06 PM, the Administrator (FA) and Director of Nursing (DON) stated for a resident-initiated discharge, the resident's representative is to be notified. Social Services gets involved and get a doctor's order. We talk to family to discuss discharge and where the placement would be. The sister was difficult to get in touch with. The FA and DON confirmed they were not aware of R60's decision-making capacity form. The FA and DON stated common practice is to call the RP and verify his documents before discharge. The FA stated that she felt bad and that was not right. The FA confirmed no discharge order in the records at 5:11 PM. (continued on next page)

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F 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/14/24 at 8:57 AM, the facility provided an acceptable IJ Removal Plan, which included: Residents who have been discharged in the past 30 days have been reviewed to validate safe, orderly discharge including living arrangements by the Director of Social Services or designee. The Administrator, Director of Nursing, and Interdisciplinary Team including the Social Worker will be reeducated by the Clinical Consultant on 6/13/24 on discharge planning including: Obtaining an order for discharge from the resident's physician. Validating community resources that are identified by the interdisciplinary team, resident, and/or family have been arranged. Providing written discharge instructions for care. Notifying the resident's legal representative, if any, or an interested family member regarding the upcoming discharge. Licensed Nurses will be reeducated on 6/13/24 by the Director of Nursing/Designee on the discharge process which includes Obtaining an order for discharge from the resident's physician. Providing written discharge instructions for care. Notifying the resident's legal representative, if any or an interested family member regarding the discharge. Licensed Nurses not receiving this reeducation by 6/13/24 will receive prior to their next scheduled shift. Anticipated discharges will be reviewed in the Clinical Morning Meeting Monday - Friday by the Interdisciplinary Team to validate preparation for a safe discharge is in place including living arrangements, family and/or responsible party notification, and physician order for discharge.

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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. 50085 Based on observations, interview, record review, and facility policy review, the facility failed to ensure a nurse followed physician orders and manufacturer's guidelines for administering an inhaled corticosteroid for 1 out of 29 opportunities of medication administration. Findings include: Review of a facility policy titled, Nursing Policies and Procedures, dated 05/05/2023, revealed, 6. The authorized staff member reads the label on the medication three times. A. Before removing the medication from the drawer, before dispensing the medication, and after dispensing the medication. 13. The authorized staff member administers medications according to accepted standards of practice and in compliance with regulatory requirements. Review of the GlaxoSmithKline instructions for use of Trelegy Ellipta, with a revised date of December 2022, revealed under Step 6, Rinse your mouth with water after you have used the inhaler and spit the water out. Do not swallow the water. Review of an Admission Record indicated the facility admitted Resident (R)87 on 06/04/24 with diagnoses including but not limited to: multiple sclerosis, insomnia, hypertension, chronic respiratory failure with hypoxia, anemia, dependence on supplemental oxygen, and chronic kidney disease. Review of R87's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/10/24, revealed R87 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident had no cognitive impairment. Review of R87's prescription order with a start date of 06/04/24, revealed Trelegy Ellipta (fluticasone-umeclidin-vilanter) blister with device; 100-62.5-25 mcg; amt: 1 puff (1 Blister); inhalation with special instructions: Rinse mouth after use. Once A Day. During an observation on 06/13/24 at 8:50 AM, Registered Nurse (RN)1 administered inhaler without instruction to exhale prior to inhaling medication. Immediately following, R87 did not rinse and spit per physician's order and manufacturer's guidelines. R87 was given by mouth medications with a cup of water to ingest. During an interview on 06/13/24 at 8:56 AM, RN1 admits to not seeing the instructions on the label and on the electronic medication administer record.

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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** 49801 Based on observations, record review, interviews, and review of the facility policy, the facility failed to follow physician orders for oxygen administration for 1 of 1 residents reviewed for respiratory care, Resident (R)41. Findings include: Review of the facility's policy titled, Respiratory Policy & Procedures dated 02/12/2024 revealed, Subject: Oxygen Therapy-Oxygen administration helps relieve hypoxemia and maintain adequate oxygenation of tissues and vital organs. Oxygen administration increases blood oxygen content so that the heart doesn't have to pump as much blood per minute to meet tissue demands. Indications: Hypoxemia, Heart failure . Procedures: A. Verify the provider's order for the oxygen therapy . Review of R41's Face Sheet revealed R41 was admitted to the facility on [DATE], with diagnoses including but not limited to: acute respiratory failure with hypoxia, chronic cough, nasal congestion, chronic systolic (congestive) heart failure, obesity, cardiomyopathy, essential (primary) hypertension, unspecified atrial fibrillation, and weakness. Review of R41's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 04/15/24, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R41 was cognitively intact. Review of R41's Care Plan with a start date of 02/28/24 and a target date of 07/15/24 documented, problem [R41] .is at risk for respiratory distress/SOB due to Dx of: CHF. Documented goal [R41] .will not exhibit or develop respiratory distress as evidenced by no SOB, O2 sat at or above 95%. Documented approach revealed, standard chest x ray with start date 06/04/24, ask resident if having trouble breathing while lying flat. Document with start date 02/28/24, monitor vital signs q shift and PRN. Document with start date 02/28/24, Apply O2 as ordered. Change O2 tubing/nasal cannula/mask/humidification system weekly. Change tubing/mask weekly. Keep O2 cannula/mask/tubing and bagged when not in use with start date 02/28/24, Encourage/teach how to cough and deep breath with start date 02/28/24, Elevate head of bed as needed with start date 02/28/24, Administer medications as ordered. Monitor adverse reaction. Contact MD if noted with start date 02/28/24, Monitor respiratory status daily during treatment period. Respiratory distress s/sx: -Shortness of breath. -Fast breathing, or taking lots of rapid, shallow breaths. -Fast heart rate. -Coughing that produces phlegm. -Blue fingernails or blue tone to the skin or lips. -Extreme tiredness. -Fever. -Crackling sound in the lungs with start date 02/28/24. Review of R41's Medication Administration Record (MAR) for 06/01/24 - 06/24/24, revealed an order for O2 at 2 liters per minute via nasal cannula, check O2 sats Q shift, Every Shift, Third, First, Second. Review of R41's Physician Order with a start date of 06/12/23 documented, O2 at 2 liters per minute via nasal cannula, check O2 sats Q shift, Every Shift. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 06/13/24 at 9:52 AM, R41 was wearing oxygen at 1L/min via nasal cannula. Resident stated the oxygen was supposed to be on 1L/min but was working on being weaned off. Oxygen tubing and water bottled was dated 06/12/24. During a record review on 06/13/24 at 10:17 AM, physician orders were verified for oxygen at 2L/min. During an observation on 06/13/24 at 7:27 PM, the oxygen flowrate was set at 1L/min. via nasal canula. During an interview on 06/13/24 at 7:29 PM, Licensed Practical Nurse (LPN)5 verified oxygen orders for R41 and reported that the order was for 2L/min. LPN5 observed the flow rate at eye level. LPN5 began adjusting the flow rate and surveyor asked what was the previous rate. LPN5 confirmed the flow rate was at 1L/min. and was adjusting to match the order to 2L/min. LPN5 explained that the order was for 2L/min. LPN5 concluded, I don't know why it was on 1L/min. During an interview on 06/14/24 at 9:12 AM, the Director of Nursing (DON) revealed nursing expectations to ensure accuracy of oxygen flow rates at the bedside as compared to the orders. The DON stated the nurse should review the orders which provides the flow rate and when validating the order during the shift, the nurse should visualize the flow rate at bedside to ensure accuracy.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46934 Based on observation, interviews, record review, and review of the facility's Dialysis Contract, the facility failed to ensure communication with the dialysis center for 1 of 1 resident (Resident (R)75) reviewed for dialysis. Findings include: Review of the facility's Dialysis Contract titled, Long Term Care Facility Dialysis Services Agreement, dated October 25, 2012, states under section 2B, Care facility agrees to furnish at the time of referral and request for acceptance of any Resident as a patient of Dialysis Center all appropriate medical and administrative information relating to resident condition, including without limitation the following. Resident's name, address, date of birth, and Social Security Number. Name, address, and telephone number of Resident's next of kin. Appropriate Payor information for Resident. Appropriate medical records of Resident, including the history of Resident's renal illness and record of laboratory and x-ray findings. Statement of current treatment including medications. Name, address, and telephone number, of the physician referring Resident, who is a physician with admitting privileges at Dialysis Center; and Advance Directives, if any, executed by the resident. Under Section 4. Care Facility Obligations stated, (a) Care Facility will provide to Dialysis Center . all information described in Section 2(b) above relating to any Resident accepted for dialysis services which is necessary or useful in connection with the provision of dialysis services to such Resident. (c) Care Facility will have the responsibility for arranging . transportation . Care Facility will be responsible for determining that Resident is in a medical condition to undergo any such transportation to Dialysis Center . Review of R75's Face Sheet revealed R75 was admitted to the facility on [DATE], with diagnoses including but not limited to: end-stage renal disease (ESRD) and was dependent on hemodialysis. Review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/01/24, revealed R75 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R75 was cognitively intact. In addition, the assessment revealed R75 was receiving dialysis and had no skin issues. Review of R75's Dialysis Care Plan revealed problem start date 05/07/24. [R75] is receiving: [x] Hemodialysis, [ ] Peritoneal dialysis Due to End Stage Renal Disease. He goes to Carolina Dialysis M-W-F at 5:30 am chair time. Review of the R75's dialysis communication book revealed there were only three (3) communication forms in the book, with the following dates: 05/31/24, 06/10/24, and 06/12/24. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/12/24 at 2:33 PM, R75 revealed that he goes to dialysis three (3) days a week, Monday, Wednesday, and Friday, for four (4) hours a day. R75 states there is no good communication between dialysis and the facility because the dialysis center tries to get the facility to do so many things such, as communication forms, for weeks and weeks they didn't do it. The dialysis center called and complained that the third shift would give attitudes to them. The communication sheets address blood pressure, but they are not doing it. They write something down. There have only been a few times I took a form with me, but normally I go with nothing, just snacks. During an interview on 06/14/24 at 10:42 AM, Licensed Practical Nurse (LPN)1 states she is an agency nurse who has been employed with the facility for six (6) months. LPN1 stated for residents who attend dialysis, there is a communication book for each resident. Residents are supposed to take the book to dialysis, with a new communication form with vitals, and medication list, and are to check the resident's port before leaving the facility. For residents who have early dialysis chair time prior to 6 am, it is the third shift's responsibility to make sure they are ready to go. When a resident comes back from dialysis, nurses are responsible for obtaining another set of vitals upon return from the dialysis facility, and ensuring the resident has their communication book. During an interview on 06/14/24 at 11:04 AM, R75 stated, I don't have my book, I didn't take it today. I don't know where my paper is at. During an interview on 06/14/24 at 11:10 AM, LPN2 confirmed she was R75's nurse for the 1st shift and she is an agency nurse. LPN2 stated, I came in at 7 this morning, the previous nurse told me he was LOA to dialysis and didn't communicate any vitals from him being sent out. When the resident came back at 10:57 he didn't have a paper, I followed him to his room and took his vitals. He should have been sent out with a form, and I would have filled out the bottom portion of the form that would have been kept in the binder. During an interview on 06/14/24 at 11:13 AM, the Director of Nursing (DON) confirmed she was familiar with R75's care, including dialysis. The DON states her expectations of facility staff, specifically nurses, is to ensure any resident who goes out to dialysis has a communication form each time a resident goes out via transport. The communication form should address all vitals such as blood pressure, temperature, pulse, and if the resident has taken their medication prior to leaving the facility. The forms are to be kept in the resident's communication book and the resident is to take the book with them, and upon return from dialysis, nurses should repeat vitals and document at the bottom of the form. Staff are to ensure all communication forms of all visits are kept in the book. During an interview on 06/14/24 at 10:01 AM, the Facility Administrator (FA) stated she and the DON could not locate R75's dialysis book. The FA stated normally the book would be at the nurse's station, or the resident took it with him. At 11:27 AM, the FA stated she would ask a medical records staff member to look for the resident's dialysis communication forms. At 12:38 PM, the FA provided R75's communication book along with a dialysis contract. The FA stated that the expectation of her staff, specifically nurses, is to ensure all communication forms are in the resident's book. The FA concluded she does not have an explanation as to why they aren't doing what is expected of them.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50085 Based on observations, interviews, and record review, the facility failed to ensure Certified Nursing Assistants (CNA)s and Licensed Practical Nurses (LPN)s were provided needed competency training for colostomy care and maintenance. Specifically, a CNA provided skilled nursing care to Resident (R)23's colostomy wafer that was beyond their scope of practice, for 1 of 2 residents observed for colostomy care. This failure had the potential to cause harm to R23's stoma. Findings include: Review of the Nurse Aide Candidate Skill Checklist also known as Skills Listing South Carolina Nurse Aide Candidate Handbook dated 07/01/23 reveals no competency skills or training for stoma assessment, care, and/or colostomy wafer changes. Review of R23's Face Sheet revealed R23 was admitted to the facility on [DATE], with diagnoses including but not limited to: Schizophrenia, urinary incontinence, psychotic disorder with delusions, hallucinations, Bell's Palsy, colostomy, and intellectual disabilities. Review of R23's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/29/24 revealed a Brief Interview for Mental Status (BIMS) score of 8 out of 15, indicating R23 had moderate impaired cognition. This MDS revealed that R23 required partial to extensive assistance of one person support with Activities of Daily Living (ADLs). Review of R23's Care Plan revealed, [R23] requires the use of a colostomy history of bowel obstruction. [R23] picks and takes off colostomy resulting in multiple colostomy during the day by nurse. [R23] cannot change colostomy related to cognitive impairment. [R23] does not clean hands appropriately causing feces to be smeared at times. Goals are: [R23] will not have any skin breakdown, will remain clean and remain patent/functional thru next review date. Approaches to meet goals include, Provide ostomy care per order to keep ostomy patent without leakage. The nurse checks colostomy every shift and change as needed. Change colostomy as needed, if more than once a shift. Notify physician of any abnormal findings. Monitor site for swelling, pain, and/or redness. Document ostomy care in clinical record. Review of R23's Physician Orders revealed, Change colostomy appliance as needed and if needed more than twice in shift. Check resident colostomy for appropriate adherence every shift and change if needed. Change colostomy wafer and bag twice a day. During an observation and interview on 06/14/24 at 10:25 AM, surveyor observed CNA3 tell CNA2 that she is to do R23's colostomy. CNA3 agreed to help her with this task since she was being interviewed. CNA2 continued interview with surveyor and revealed changing the colostomy wafer and bag is a regular task for the CNAs. (continued on next page)

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 06/14/2024

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

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 06/14/24 at 10:38 AM, surveyor observed CNA3 taking Medi pore tape off R23. R23 was lying supine on the bed with his shirt up and a green yellowish substance leaking around the tape that had not been taken off. CNA3 cut Medi pore tape on the bedside table with wafer. CNA3 stated this is not a task she should be doing but was directed by the nurse to complete. During an interview on 06/14/24 at 10:56 AM, LPN1 revealed she works at the facility 2-3 times a week. LPN1 reveals that since employed six months ago certified nursing assistants have been providing total colostomy care to residents. No one told her any different, so she thought it was fine. LPN1 reports that a CNA changed his bag this morning already but did not want to give the name. LPN1 verified telling CNA2 and CNA3 to do R23's colostomy wafer and care. LPN1 further stated she does not sign off on treatment administration if the CNAs complete the treatment. LPN1 revealed she does the colostomy treatments from time to time and only then will she sign the treatment administration record. During the interview LPN1 showed this surveyor a note saying she does not want to get in trouble, but the CNAs do dressing changes too. During interview on 06/14/24 at 11:08 AM, CNA3 revealed she has changed and witnessed several CNAs do dressing changes and change colostomy wafers and bags. CNA3 states she was told by nurse weekend supervisor, she had to do it. CNA3 states if a surveyor would not have stopped this process, she would have done it today. CNA3 verified LPN1 told her or CNA2 to do the colostomy care with the wafer and bag. During an observation and interview on 06/14/24 at 11:15 AM, surveyor observed R23 with his curtain open and his shirt still up exposing his stomach. R23 was laying across the bed supine. R23 states a CNA was changing him but stopped. Can one do it now? R23 was rubbing his head visibly upset. R23's bag and dressing was exposed with several cut pieces of Medi pore tape on the bedside table. A yellow greenish hue colored substance was leaking from the wafer, soiling the tape. During an interview on 06/14/24 at 11:20 AM, CNA2 revealed she has done colostomy wafers and bag changes. CNA2 stated she did not know the wafer or stoma required measurements. CNA2 explained that she normally put it against him and cut a hole in the thing. CNA2 further stated, I have changed dressings all the time if it is a dry dressing or do not have ointment or anything. The nurses give us the dressings because the treatment carts are locked so how are we getting it? They are the only ones with the key. During an interview on 06/14/24 at 11:34 AM, the Director of Nursing (DON) revealed not being aware that CNAs were doing the dressings or colostomy treatments. The DON stated there is a policy in place and staff know how to work within their scope of practice. The DON revealed that she will follow up with the CNAs. The expectation is that CNAs do not work outside their scope of practice.

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 06/14/2024
NAME OF PROVIDER OR SUPPLIER Magnolia Manor - Spartanburg		STREET ADDRESS, CITY, STATE, ZIP CODE 375 Serpentine Drive Spartanburg, SC 29303	

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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** 49818 Based on observation, record review, interviews, and review of facility policy, the facility failed to ensure that staff used proper Personal Protective Equipment (PPE) while providing colostomy care to 1 of 8 residents, Resident (R)17. Findings include: Review of the facility policy titled, Transmission Based/Standard Precautions, and Enhanced Barrier Precautions, revised on May 15, 2023 stated, Policy: 2. Healthcare worker (HCW) will implement Universal/Standard Precautions whenever there is the occupational exposure to blood and body fluids, 4. The type of PPE (personal protective equipment) and precautions implemented depends on the potential for exposure, route of transmission, and the infectious organism/pathogen, 5. Health care workers will implement enhanced barrier precautions according to policy with additional measures to protect residents and staff from Multidrug-resistant Organisms (MDROs) MDROs refers to microorganisms predominantly bacteria that are resistant to one or more classes of antimicrobial agents. Procedures: Enhanced Barrier Precautions (EBP) 1. Enhanced Barrier Precautions expand the use of the PPE (gowns and gloves) during high contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. A. EBP will be implemented for All residents with the following: 2. Wounds and/or indwelling medical devices(central lines, urinary caterer, feeding tube, tracheostomy/ventilator) regardless of MDRO colonization status B. EBP will be implemented during the following high-contact resident care activities: 6. Changing briefs or assisting with toilet 7. Device care or uses: central lines, urinary catheter, feeding tube, tracheostomy/ventilator C. EBP requires the following PPE: 1. Gloves 2. Gown 3. Face Protection is performing activity with risk of splash or spray 4. All PPE is donned (put on) and doffed (removed) with appropriate hand hygiene and disposable after individual use or when visibly soiled. Review of R17's Admission Record revealed R17 was admitted to the facility on [DATE], with diagnoses including but not limited to: Schizophrenia, unspecified viral Hepatitis C without hepatic coma, anxiety disorder, major depressive disorder, Streptococcus group A as the cause of diseases classified elsewhere, carrier or suspected carrier of Methicillin resistant Staphylococcus aureus, and pressure ulcer of sacral region Stage 4. Review of R17's Physician Order Report for the month of June 2024, revealed an order with a start date of 09/25/23 for, Enhanced Barrier Precaution r/t (related to) MRSA start date of 09/25/23 to empty colostomy bag q (every) shift. May be emptied by CNA. Review of R17's Care Plan with a revised date of 05/22/23, revealed the resident is continent of bladder, foley catheter, bowl and is at risk for skin breakdown r/t (related to) catheter and colostomy. Interventions initiated on 05/22/23, revealed to change colostomy wafer and bag every 3 days and prn (as needed), empty colostomy bag every shift and prn, may be emptied by nsg (nursing) assistant, observe colostomy site every shift and prn for evidence of redness and breakdown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R17's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/29/23, revealed R17 had Brief Interview for Mental Status (BIMS) of 15 out of 15, indicated the resident was cognitively intact. Further review of the MDS revealed R17 had an indwelling catheter and Ostomy (colostomy). During an observation on 06/12/24 at 11:25 AM, Certified Nursing Assistant (CNA)1 was observed entering R17's room, which signage indicated Enhanced Barrier Precautions. CNA1 entered R17's room without sanitizing their hands, or putting on proper PPE. CNA1 proceeded to check R17's colostomy bag. During an interview on 06/12/24 at approximately 11:35 AM, CNA1 revealed, I should have put on a gown. CNA1 explained the proper procedure for providing direct care in regard to emptying R17's colostomy, they should have worn a gown, gloves and a mask while providing care. CNA1 concluded, I just wasn't thinking. During an interview on 06/14/23 at 4:15 PM, the Director of Nursing (DON) and the Administrator revealed that staff should use proper PPE when providing direct care to residents on EBP. The DON and the Administrator explain that direct care includes transfers, incontinent care, and bed baths. Both the DON and the Administrator state that it is their expectation that staff perform hand hygiene by washing their hands or using alcohol based sanitizer and dress out in the proper PPE provided.