

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  425165	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/25/2024
NAME OF PROVIDER OR SUPPLIER  Magnolia Manor - Rock Hill		STREET ADDRESS, CITY, STATE, ZIP CODE  127 Murrah Dr Rock Hill, SC 29732	

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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48214</b></p> <p>Based on review of facility policy, interviews, and record reviews, the facility failed to protect 2 of 3 residents from misappropriation of controlled substances and 1 of 3 residents from misappropriation of routine medications, Residents (R)1, R2, and R3.</p> <p>Findings include:</p> <p>Review of the Facility Policy titled Abuse, Neglect, Exploitation, or Mistreatment dated 10/23/19, states, The facility's Leadership prohibits neglect, mental, physical . and misappropriation of a patient's/resident's property and/or funds .</p> <p>Review of the Facility Policy titled Receipt of Controlled Substances dated 04/01/22, states, The licensed nurse receiving the medication must verify the contents, quantity, and sign the Packing Slip in the presence of the driver. Furthermore, it states, The licensed nurse accepting the Controlled Medication(s) immediately places the controlled medications into an appropriate separately locked, permanently affixed compartment.</p> <p>Review of R1's Face Sheet revealed R1 was admitted to the facility on [DATE], with diagnoses including but not limited to: spinal stenosis, pressure ulcer of sacral region, unstageable, fusion of spine and gout. Further review of R1's Face Sheet revealed R1 was discharged from the facility on 03/15/24.</p> <p>Review of R1's Physician Orders dated 02/16/24, revealed the following orders: oxycodone 30 mg Twice a Day (BID) and oxycodone-acetaminophen 10-325 mg BID as needed (PRN).</p> <p>Review of R1's Medication Administration Record (MAR) dated February 2024, revealed on 02/16/24, 02/17/24, and 02/18/24, R1 did not receive his scheduled dose due to the medication being on hold.</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 pain, hemiplegia and hemiparesis, ileus and acute kidney failure.</p> <p>Review of R2's Physician Orders dated 01/03/24, revealed an order for tramadol 50 mg every six hours (Q6H) PRN for chronic pain.</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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of R2's Electronic Medical Record (EMR) on 02/25/24 revealed a Nurses Note dated 02/20/24 at 10:44 AM that stated, Pharmacy notified regarding refill needed for tramadol. Per pharmacist, patient with refills on script, requires signature for delivery. Signature request to be sent to DON. Insurance to cover medication starting 2/22. per pharmacist no escript [SIC] needed for pull from ekit. [RN].</p> <p>Review R2's EMR) on 02/25/24 revealed a Nurses Note dated 02/20/24 at 12:53 PM that stated, Tramadol pulled from narcotic ekit. Code verified by pharmacist. Form faxed to pharmacy. Medication effective after 30 minutes. [RN]</p> <p>Review of a facility delivery manifest titled Magnolia Rock Hill Wing 1 dated 02/16/24, revealed that at 9:07 PM Registered Nurse (RN)1 signed for 30 tablets of 50 mg tramadol for R2, 6 tablets of 10-325 mg oxycodone-acetaminophen and 9 tablets of oxycontin 30 mg for R2.</p> <p>Review of R3's Face Sheet revealed R3 was admitted to the facility on [DATE], with diagnoses including but not limited to: Type 2 diabetes mellitus, long-term (current) use of injectable non-insulin antidiabetic drugs, long term (current) use of insulin and morbid severe obesity.</p> <p>Review of R3's Physician Orders dated 01/29/24, revealed an order for Ozempic pen injector (non-insulin antidiabetic drugs).</p> <p>Review of R3's MAR dated February 2024, revealed that on 02/19/24, R3 did not receive her scheduled dose of Ozempic due to med not available in cart.</p> <p>Review of a facility delivery manifest titled Magnolia Rock Hill Wing 1 dated 01/25/24. Revealed the delivery of one three milliliter (ML) Ozempic pen injector for R3.</p> <p>Review of a Telephone Correspondence Form dated 02/19/24, revealed that the Facility Administrator (FA) called the pharmacy to state that R3s medication was lost and wanted to request an early refill. The FA was informed that insurance denied the early refill and it would cost the facility \$1,021.45, the FA then stated that she would try to find something else.</p> <p>Review of a Packing Slip from Remedi SeniorCare of [NAME] dated 02/26/24, revealed the delivery of one three milliliter (ML) Ozempic pen injector for R3.</p> <p>Review of [NAME] Diagnostics Urine Screening dated 02/20/24, revealed the ADON tested negative for marijuana, cocaine, amphetamines, opiates, and PCP.</p> <p>Review of a Termination Form dated 02/26/24, revealed the Assistant Director of Nursing (ADON) was terminated from employment due to Violation of Rules/Policy.</p> <p>During an interview on 03/25/24 at 12:01 PM, R3 stated that she was told on four different occasions that her Ozempic was missing and that she could not get her ordered dose. R3 further stated that she is supposed to take it every Monday but does not always receive it. R3 also reports that she was supposed to receive her Ozempic today, but the nurse stated to her that they are trying to get it replaced.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 03/25/24 at 12:12 PM, R2 states that she has been in the facility for a few months. R2 further states she has not missed any doses of medication, nor has she been in any pain.</p> <p>During an interview on 03/25/24 at 1:38 PM, the Director of Nursing (DON) stated that the Assistant Director of Nursing (ADON) had signed the delivery manifest acknowledging receipt of narcotic medications from the driver. The DON further revealed that the ADON stated she placed the medications down on the counter and returned about 30 minutes later to put them away and doesn't remember any narcotics in the delivery nor does she know where they are. The DON further states that it is her expectations that there should be two nurses signing for the delivery of any narcotic medications and that they needed to verify the bag number and the contents of the bag before receiving the delivery of medications and if there is a discrepancy staff is to call the pharmacy and not accept the delivery. The DON confirms the misappropriation of R1's Oxycodone, R2's Tramadol and R3's Ozempic.</p> <p>During an interview on 03/25/24 at 2:01 PM, RN1 stated that on 02/18/24 during med pass it was noted that R1's scheduled Oxycodone was not in the building. RN1 reports that she then called the pharmacy who reported to her that R1's medication had already been delivered on 02/16/24. RN1 reports she then notified the DON, FA, and R1's physician of the missing narcotics.</p> <p>Multiples attempts were made to contact the ADON, but were unsuccessful.</p>		