

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 06/10/2024
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48214</p> <p>Based on interview, record review, and review of facility policy, the facility failed to provide appropriate care and services to ensure Resident (R)1's quality of life, specifically Licensed Practical Nurse (LPN)1 failed to accurately assess R1, who expired approximately 30 minutes later.</p> <p>On [DATE] at 3:02 PM, the survey team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template, informing the facility IJ existed as of [DATE]. The IJ was related to 42 CFR 483.25 - Freedom from Abuse, Neglect, and Exploitation.</p> <p>On [DATE] the facility provided an acceptable IJ Removal Plan. On [DATE] the survey team validated the facility's corrective actions and the immediacy of the IJ was removed as of [DATE]. The facility remained out of compliance at F600 at a lower scope and severity of D.</p> <p>An Extended Survey was conducted in conjunction with the Complaint Survey for non-compliance at F600, constituting substandard quality of care.</p> <p>Findings include:</p> <p>Review of a facility policy titled Abuse, Neglect, Exploitation or Mistreatment last revised on [DATE], states, The facility's Leadership prohibits neglect, mental, physical and/or verbal abuse . Under the section definitions revealed, 2. Adverse event. An adverse event is an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof. 6. Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Under the section titled III: Prevention revealed, 4. Adequate supervision of staff is maintained in order to identify and prevent inappropriate behaviors, such as. C. Ignoring the patient's/residents needs requests, etc. 5. Ongoing assessment, care planning, and monitoring of those patients/residents with special needs that may lead to neglect, for example: E. Patients/residents requiring excessive nursing care or staff attention.</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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of a facility policy titled, Physician and Other Communication/Change in Condition last revised [DATE], states, 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 a patient's/resident's condition, and provide guidance for the notification of patients/residents and their responsible party regarding changes in condition.</p> <p>Review of R1's Face Sheet revealed R1 was admitted to the facility on [DATE], with diagnoses including but not limited to: dementia, altered mental status, hypertensive heart disease, cerebral ischemia, metabolic encephalopathy, Type 2 Diabetes, and atrial fibrillation.</p> <p>Review of R1's Physician Order revealed an order dated [DATE], stating R1 had an advance directive for Full Code status.</p> <p>Review of R1's Nursing Progress Note dated [DATE] at 7:29 AM, revealed CNA went into residents' room approximately 6:30 am to bathe resident it is his bath day. CNA left room. At 0700 returned to room to do care for another resident noticed that the resident was not breathing. 911 called and CPR initiated.</p> <p>Review of R1's Nursing Progress Note dated [DATE] at 7:48 AM, revealed Emergency services arrived at facility approximately 7:10 am. Emergency services performed. Time of death called at 7:33am. On call provider NP called. Ems called Coroner.</p> <p>Review of the Rock Hill Fire Department (RHFD) South Carolina Pre-Hospital Care Report dated [DATE], revealed that RHFD was listed as En route at 7:19 AM and was the first Emergency Medical Service (EMS) unit to arrive at the facility at 7:23 AM. Further review revealed an Assessment Summary that stated, [R1] was unresponsive, not breathing and his skin was cold.</p> <p>Review of the [NAME] Medical Center (PMC) EMS South Carolina Pre-Hospital Care Report dated [DATE], revealed, PMC EMS arrived at the facility at 7:28 AM. Further review revealed a Patient Care Report that stated, Ems was dispatched priority 1 to incident location for unconscious not breathing. Upon arrival Ems located pt in room at nursing facility. pt being attended by rock hill fire dept first responders. First responders stated upon there arrival pt had been found by nursing home staff unresponsive not breathing. They provided some cpr till there arrival. nursing home staff had last contact with pt earlier this date around 45 -60 minutes prior to him being found. pt was at his normal baseline at that time. Obvious death. code black at 0733.</p> <p>During an interview on [DATE] at 10:36 AM, the Deputy Coroner (DC) stated R1's listed time of death was at approximately 7:00 AM.</p> <p>During an interview on [DATE] at 11:17 AM, Certified Nursing Assistant (CNA)3 stated he last checked on R1 at about 4:30 AM when he started his rounds, CNA3 reports the day shift staff were the ones to find R1, however he does not know if CPR was initiated, or EMS called.</p> <p>During an interview on [DATE] at 11:40 AM, CNA2 stated R1 died while CNA1 was cleaning him up, and that LPN1 was notified.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 11:44 AM, CNA1 revealed she arrived at approximately 5:55 AM to begin her shift. CNA1 stated to the other aid that R1 is about to die and notified LPN1. CNA1 then stated she gave R1 a bath at approximately 6:20 AM and when she returned to finish his care at 6:22 AM, R1 was deceased . CNA1 does not know if EMS was called, or if CPR was performed at that time.</p> <p>During a follow up interview on [DATE] at 12:44 PM, CNA1 revealed during shift change she and CNA2, noticed that R1's breathing had become slowed and that R1 was not talking and responding as usual. CNA1 then notified LPN1 and CNA3 of the changes, in which they both replied that R1 was not in that condition earlier on the night shift rounds. CNA1 further stated after notifying LPN1, LPN1 walked in R1's room, looked at him and then proceeded to sit at the nurse's station.</p> <p>During an interview on [DATE] at 12:34 PM, the Interim Director of Nursing (DON) stated that when residents have a significant change, the CNA is to notify the nurse, who then performs an assessment on the resident, and notifies the provider as necessary. The DON further states that residents who are on palliative care and are full code, require CPR just as any other full code resident.</p> <p>During an interview on [DATE] at 3:46 PM, LPN1 revealed that it was reported to her that R1 did not look right. LPN1 stated that she went into R1's room, looked at him, then went to check his code status. LPN1 further stated approximately 20 minutes later, CNA1 notified her that R1 was now unresponsive, and that's when LPN1 called a Code and grabbed a crash cart. LPN1 concluded the physician was not notified at any time during the incident, and she did not provide R1 with any care until after he was unresponsive. LPN1 could not provide/nor recall any documentation for the morning of the incident.</p> <p>On [DATE], the facility provided an acceptable IJ Removal Plan, which included the following:</p> <ol style="list-style-type: none"> 1. R1 no longer resides in the facility. 2. A review of the 24hour report and facility activity report was completed on [DATE] by the Facility Administrator beginning [DATE] through [DATE] to identify possible allegations of abuse or neglect and to review residents with change of conditions. 3. Facility Staff were re-educated by the Administrator on [DATE] Abuse, Neglect and Misappropriation policy. 4. Facility Administrator/Interim DON will re-educate licensed staff on Change of Condition. 5. Administrator contacted Regional Ombudsman on [DATE]. 6. The Director of Nursing/Designee will review the 24-hour report and the Facility Activity report to identify any documentation regarding a change of condition, abuse and validate that the resident has been assessed appropriately, physician notified, responsible party notified, and orders implemented properly. This includes diagnostic testing and results. This will be completed in the Clinical Meeting. 7. The results of this monitoring will be presented to the Quality Assurance/Performance Improvement Committee for a period of three months for review and recommendation. Any identified concerns will be addressed at the time of discovery. <p>(continued on next page)</p>		

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