STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425165	A. Building B. Wing	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Manor - Rock Hill	127 Murrah Dr Rock Hill, SC 29732

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49918 Based on review of facility policy, record review and interviews, the facility failed to protect Resident (R)1 from physical, verbal, and mental abuse by Licensed Practical Nurse (LPN)1. Specifically, LPN1 used inappropriate language to address R1. Furthermore, witnesses observed LPN1 physically hit R1, as a reaction to R1 hitting LPN1. The State Agency (SA) utilizing the Reasonable Person Approach, has determined that any reasonable person in the same situation would experience adverse psychosocial harm. On 01/13/25 at 3:18 PM, the Director of Nursing was notified that the failure to protect a resident from physical and verbal abuse constituted Immediate Jeopardy (IJ) at F600. On 01/13/25 at 3:18 PM, the survey team provided the Director of Nursing with a copy of the CMS Immediate Jeopardy (IJ) Template, informing the facility IJ existed as of 11/22/24. The IJ was related to 42 CFR 483.12 - Freedom from Abuse, Neglect, and Exploitation. On 01/13/25, the facility provided an acceptable IJ Removal Plan. On 01/13/25 the survey team validated the facility's corrective actions and determined the facility put forth due diligence in addressing the noncompliance. The IJ is considered at Past Noncompliance as of 11/25/24. An extended survey was conducted in conjunction with the Complaint Survey for noncompliance at F600, constituting substandard quality of care. Findings include: Review of the facility's policy titled, Abuse, Neglect, Exploitation, or Mistreatment revised on 11/01/17, documented, The facility's Leadership prohibits neglect, mental, physical and/or verbal abuse, use of a physical and/or chemical restraint not required to treat a medical condition . III. Prevention Adequate supervision of staff is maintained in order to identify and prevent inappropriate behaviors, such as: A. The use of derogatory/harassing language; B. Rough handling; and C. Ignoring the patient's/residents needs requests, etc. Component IV: Identification (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Neglect is the failure to provide goods and services or treatment and care necessary to avoid physical harm, mental anguish, or mental illness. Types of abuse include BUT ARE NOT LIMITED TO: A. Physical assault/abuse: 1) Hitting 2) Slapping 3) Pinching 4) Kicking 5) Controlling behavior through corporal punishment 6) Physical or chemical restraints (not required to treat a medical condition) B. Mental abuse: 1) Humiliation 2) Harassment 3) Threats 4) Punishment or deprivation 5) Gestured language including, but not limited to, disparaging or derogatory terms directed to or within the patient's/resident's hearing distance. Review of R1's Face Sheet revealed R1 was admitted to the facility on [DATE], with diagnoses including but not limited to: Diffuse traumatic brain injury with loss of consciousness, subluxation of C3/C4 cervical vertebrae, fusion of spine, cervical region, violent behavior, wandering in diseases classified elsewhere, unsteadiness on feet, cognitive communication deficit, and schizophrenia. Review of R1's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/03/24, revealed R1 had a Brief Interview for Mental Status (BIMS) score of 7 out of 15, indicating R1 had severe cognitive impairment. Review of R1's Care Plan with a problem start date of 11/15/24, revealed a problem, [R1] takes antianxiety medication. The goal documented, [R1] will not exhibit drowsiness/over-sedation . imp. cognition/behavior, disturbed balance/gait/positioning ability . injury related related to falls . Further review of the Care Plan with a problem start date of 11/15/24, revealed a problem, [R1] has risk for falling . The goal documented, [R1] will remain free from injury. The approach directed staff to, Appliance: [NAME] as needed. Encourage resident to assume a standing position slowly. Review of another Care Plan with a problem start date of 11/15/24, revealed a problem, [R1] requires supervision and occasional assistance with ADL's and transfers. He has unsteady balance and gait. The goal documented, [R1] will receive assistance as needed and will utilize walker for locomotion. The approach directed staff to, Praise resident for efforts . [NAME] for locomotion. Review of another Care Plan with a problem start date of 11/11/24, revealed a problem, [R1] wanders through out the facility, is a risk for 1. Elopement 2. Entering into others private space 3. Increased fall risk. Related to diagnosis of Schizophrenia and making comments of needing to get out of here. The goal documented, [R1] will not have negative events related to wandering, will remine [sic] safely in the facility as evidence by documentation in the medical record. The approach directed staff to, . Provide reassurance and positive reinforcement for acceptable behavior. Remind politely clearly and privately of behavioral expectations. Review of R1's Progress Note dated 11/22/24, documented, Resident returned from the ER at [local hospital] via stretcher . Upon entering the facility resident immediately become belligerent toward the transport workers. Once resident got to the unit resident refused to get off the stretcher, once resident was off the stretcher he started cursing at the staff knocked over his roommates dinner tray. Resident started swinging at the CNA and hit her in the left arm. Kicked at the nurse and the transport worker. Resident then proceeded to follow the transport workers out of the building cursing at staff and threatening to kill us all . Resident was unable to be redirected or calmed down he walked toward the train tracks and slipped on the rocks, still belligerent and combative did not allow nurses to help him up eventually he calmed down enough and allowed CNA to assist him up off the ground . 911 called and police came stated they could not legally remove him from the facility without a doctors order . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Police Report dated 11/25/24, documented, Offense ASSAULT AND BATTERY 3RD DEGREE. Further review of the Police Report revealed a narrative by the reporting officer which documented, On November 25, 2024, [officer's names] spoke with [unidentified facility staff] about an incident that occurred at [facility address], which is within the city limits of Rock Hill, South Carolina, about an incident that occurred on November 22nd, 2024. [unidentified facility staff] stated that a patient of theirs by the name of [R1] was assaulted by a nurse of theirs, and based on statements made from witnesses witnessed [R1] come back from the hospital and was very disorderly with staff. instead of deescalating the situation she was said to have made comments belittling [R1] and then proceeded to strike his arm. The strikes to the arm according to [facility staff] did not leave any marks or bruising . Review of a document titled Termination Form, for LPN1, signed on 11/27/24, documented, Effective Date: 11/27/24 Last Day Worked: 11/22/24. Action: Termination Involuntary Gross Misconduct, Violation of Rules/Policy Review of a Corrective Action Form, for LPN1, dated 11/27/24, documented, Reason for Action (include policy if applicable): Allegation of abuse substantiated. Action Required: Employee terminated related to gross misconduct and violation of rules/policy. During an interview on 12/12/24 at 3:47 PM, Certified Nursing Assistant (CNA)1 stated, I was working on Unit 2 when an AmbuStar EMS (Emergency Medical Services) staff (AS) brought [R1] back from the hospital. When I was coming out of the resident room, the AS stopped me and asked for the nurse. I told [Licensed Practical Nurse (LPN)1] the resident was back and AS wanted to speak with her. [LPN1] stated, Are you serious? When [LPN1] walked up to [R1], [LPN1] automatically started antagonizing [R1]. He was refusing to get off the stretcher. The AS stated, We have to get him off the stretcher because we cannot take him back to [local hospital]. [LPN1] then pushed [R1] off the stretcher so hard, he almost flew off the stretcher almost onto the floor. CNA1 further stated, [LPN1] antagonized [R1] the whole entire time. [LPN1] was belittling him a lot. When [R1] stood up, he called [LPN1] a F****** B****, the AS then left. The whole time [R1] and [LPN1] were going at it. It was freezing cold that day. I told [LPN1] he cannot go outside; it is freezing cold. [R1] went outside. Me and another nurse were able to get him calmed down. Then [LPN1] reinserted herself again. Then [LPN1] stated, We need to call 911. [R1] started saying I hate this B****. I am going to kill her. [LPN1] followed us outside after we got [R1] calmed down. The whole time she was on the phone with AmbuStar EMS. Also during this time another resident's family member saw [R1] on the ground and [LPN1] stated, He doesn't need any help. When [R1] got out of the facility, he went towards the railroad tracks. When [LPN1] came out, [R1] went ballistic again. [LPN1] started belittling him again and she pushed him down on the railroad tracks. I was going to help him and [LPN1] told me to get away from him. I observed [LPN1] had [R1] by the right arm and then he lost his balance. I saw [LPN1] arm motion, like she pushed him. [R1] could not get up by himself and she was telling us not to help him get up. We asked him if we could help him up, he said yes, but she (LPN1) can't help me, she is mean. [R1] had on a white t-shirt and a black pair of pants, and it was freezing cold. [R1] likes coffee so I was trying to de-escalate the situation and try to talk to him about coffee. When the Administrator arrived at the facility, she instructed me to put another wanderguard on him. I guess the hospital took his wanderguard off. [R1] is upset because his family got rid of him. They do not want anything to do with him. He tells me I am his only friend in the building. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 12/12/24 at 4:14 PM, LPN1 stated, When he first came back to the hospital, immediately he became irate and belligerent by the time he got to the building he was upset that he was back. He refused to get off the stretcher. With a lot of prompting from the staff, he got off the stretcher. He went into his room and left back out of the facility following the transport people. He proceeded to follow them and ended up on the train tracks. He has an imbalance due to his stroke. He was walking on the train tracks. I tried to redirect [R1], but he fell on the train tracks. The train tracks are on a slope. I was trying to assist, as well as redirect him. In the process of him falling, I tried to catch him by the back of his shirt, but he still ended up falling. He was so belligerent and upset. He was very upset with me. Usually, he doesn't give me a hard time. I usually set up the TV for him. That day, I don't know; I really can't determine why he was acting that way towards me. We had to call the police to try to get him back in the building. He walked back into the building. I spoke with the Officer to see what steps we can take to prevent this from occurring. The Officer stated we would need to get an order from the Physician for further direction. The only thing the police can do is take him to the hospital. The police officer talked to [R1] that night. [R1] calmed down. A little thereafter, R1 was stating his family was coming. I explained to him he shouldn't threaten us with his family. I told him his family doesn't check on you or answer your calls. LPN1 further stated, I received a call from the Director of Nursing (DON) stating I had been accused of abuse. She couldn't go into details of the events. She called me again and she still didn't tell me what I been accused of. The facility separated me working with him. From that incident, they separated me from working at that facility. I couldn't come back to work. The Administrator came in that same night. She didn't say anything to me. She came to the nurses' station and asked about a CNA. She didn't say anything in reference to the incident. During an interview on 12/12/24 at 5:13 PM, the DON stated, We talk to [R1] daily and re-assured him. He really wants to go home. [R1] is upset because he lost his independence. He is trying to keep his independence. During an interview on 12/12/24 at 5:51 PM, LPN2 stated, [R1] came down on Unit 1 cussing. So, the [AS] and I went outside to see if he was ok. I told the nurse to call 911 to see if we can get additional help to see if it was something we can do for [R1]. [LPN1] was belittling him. [R1] was saying he was going to hit [LPN1]. He went in between the railroad tracks with his walker. I missed what happened. When I turned back around to look, [LPN1] told him to walk this way. When I turned around, he was down on the railroad track. [LPN1] was making a statement to [R1] like, You can't even walk. So, [LPN2] and [CNA1] asked him can we help him up. When the CNA told me she saw [LPN1] put her hands on him, I told her we had to report it. By the time we got him up, the cops arrived. During an interview on 12/12/24 at 6:34 PM, the AS stated, The patient was aggravated. The facility told him that they were going to get his clothes and take him to his brother's house. I asked one of the staff members, Can you help me? She said, Let me go get my nurse. One lady came up and talked to him for a second. Then [LPN1] came and she said, We will piss him off to get him off the stretcher. She started saying, you need to get up. [R1] had been hitting on me then started hitting on her. I put [R1] in a lock hold position to prevent him from hitting her. We put him on the bed. [R1] hit [LPN1] hard. Then they started hitting each other multiple times. [R1] hit and kicked. He knocked his roommate's tray over. I saw [LPN1] hit him. It wasn't even a 5-minute scenario. He was hitting hard, so [LPN1] hit him back. Then that is when I left at that point. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 01/13/25 at 11:11 AM, the DON stated, Initially, I spoke with [CNA1]. I called [LPN1], after I spoke with the CNA. Then, I spoke to the two EMT transport ladies. The Administrator was on her way up here when I was speaking with [LPN1]. At this time, the Administrator spoke with [R1]. I suspended [LPN1] after questioning her prior to my investigation. The Administrator escorted her out of the building and preformed a body audit. I have not noticed any negative behaviors from [R1] since that incident. [R1] is demonstrating the same behaviors. [R1] has verbal aggression behaviors (i.e. Slamming the walker down, trying to elope, believing we are trying to keep [R1] here against [R1's] will, attempting to swing at other staff members, and cursing at the staff). [LPN1] did not have any abuse allegations prior to this event. During an interview on 01/13/25 at 11:32 AM, the Administrator stated, That day I left the facility at 5 PM. I didn't get home good when I received a call from the DON about the incident. I returned to the facility because the police were on their way. By the time I arrived back, we were able to get him something to eat and settled down. The only time [LPN1] had anything to do with him after the incident was pulling his medication. She did not go in the room with him or have any other interactions with [R1] after he returned inside the building. The incident occurred in the room where she (LPN1) pushed and hit him in the bed. Prior to this incident, [LPN1] did not have any additional reprimands in her record. The only other thing I was aware of was the nursing board was looking into [LPN1] improperly failed to assess a resident. That occurrence was also for this facility. On 01/13/25, the facility provided an acceptable IJ Removal Plan, which included the following: Resident #1 resides in the facility without negative effect. Medical Director notified on 11/22/2024 of incident. No reported concerns. Resident #1 was reviewed and observed for physical and or psychosocial issues, none identified. Incident Reported to all three state agencies at time of notification. Alleged perpetrator was suspended immediately pending investigation All residents who reside in the facility have the potential to be affected. Administrator/Designee interviewed 10 alert and oriented residents and observed 10 non-oriented residents for signs and symptoms of abuse on 11/22/2024. Director of Nursing/Designee completed body adults on interviewed and observed residents on 11/22/2024. A review of the 24-hour report and facility activity report was completed on 11-22-2024 by the Facility Administrator beginning 11-21-2024 through 11-22-2024 to identify possible allegations of abuse or neglect and to review residents with change of conditions. No concerns identified at this time. Facility Staff were re-educated by the Administrator on Abuse, Neglect and Misappropriation policy including: Identification of abuse or neglect, by observable and objective evidence, witness reports of unusual occurrence or patterns or trends of potential abuse or neglect (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Abuse is the willful infliction of injury unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual of goods or services that are necessary to maintain physical, mental and psychosocial wellbeing. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse. Immediate identification and removal of the alleged perpetrator Identification and assessment of the alleged victim Reporting immediately to Facility Abuse Coordinator, Director of Nursing, and Social worker regardless of time of day This reeducation began immediately and was completed 11/25/2024. Any staff not receiving this information prior to this date will receive prior to next schedule shift. This education will be presented in New Hire and agency staff orientation. Administrator contacted Regional Ombudsman on 11/22/2024. Director of Nursing or ADON will observe care of 3 residents 3 times per week to monitor for forceful and/or aggressive care of residents for 4 weeks beginning week of 11/22/2024 and then monthly for 3 months. Will address any identified issue at time of discovery. Social Services Director will interview 5 alert and oriented residents randomly weekly for 4 weeks then monthly for 2 additional months to validate that residents feel safe and have no concerns of aggressive treatment. 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. Ad Hoc QAPI was held on 11/22/2024. The Medical Director was notified of the Immediate Jeopardy on 01/13/2025. Allegation of Compliance 11/25/2024.