

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  425172	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/08/2024
NAME OF PROVIDER OR SUPPLIER  Magnolia Manor - Greenwood		STREET ADDRESS, CITY, STATE, ZIP CODE  1415 Parkway Drive Greenwood, SC 29646	

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 - Minimal harm or potential for actual harm</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49818</p> <p>Based in record review, interviews, and review of facility policy, the facility failed to ensure Residents (R)1 and R2 were free from verbal abuse for 2 of 2 residents reviewed.</p> <p>Findings include:</p> <p>Review of the facility's undated policy titled Abuse, Neglect, Exploitation, or Mistreatment revealed, The facility's Leadership prohibits neglect, mental, physical and/or verbal abuse . 1. Definitions as defined by CMS section 483.5: 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, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled using technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.</p> <p>Review of R1's Face Sheet revealed R1 was admitted to the facility on [DATE] with diagnoses including but not limited to: cerebral infarction due to unspecified occlusion or stenosis of left middle cerebral artery, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, depression, and Type 2 diabetes mellitus without complications.</p> <p>Review of R1's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/23/24 revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating R1 has moderate cognitive impairment.</p> <p>Review of R1's Social Services Progress Note dated 02/16/2024 at 1:37 PM, revealed, Spoke with resident and he states that he is ok and that everything is fine. He does not show any signs of distress and he is happy with having his door open.</p> <p>Review of R1's Social Services Progress Note dated 02/19/24 at 4:36 PM, revealed, SSD spoke with resident on today and there are no signs of any issues with psychosocial wellbeing. Resident has been in good spirits and was involved in daily routine.</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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R2's Face Sheet revealed R2 was admitted to the facility on [DATE] with diagnoses including but not limited to: dementia, chronic obstructive pulmonary disease with (acute) exacerbation, vascular dementia, and major depressive disorder.</p> <p>Review of R2's Quarterly MDS with an ARD of 01/23/24 revealed a BIMS score of 15 out of 15, indicating R2 is cognitively intact.</p> <p>Review of R2's Social Services Progress Note dated 02/16/24 at 1:04 PM, revealed, [Recorded as Late Entry on 02/19/2024 01:06 PM] SSD spoke with resident and he showed no signs of distress but he stated that something better be done with the nurse. He does not appreciate being hollered at for no reason.</p> <p>Review of R2's Social Services Progress Note dated 02/19/24 at 4:40 PM, revealed, SSD spoke with resident and he was asking questions about the outcome of the incident and he stated that he didn't deserve that type of abuse from anyone. Resident was upset about the situation and continued to talk about it through out the day. SSD asked would he like to discuss his feelings with psych but he declined.</p> <p>R1 was not available for interview, due to hospital admission on 04/01/24.</p> <p>During an interview on 04/08/24 at 10:25 AM, R2 revealed that staff had talked to him mean and offensively. R2 stated The incident happened months ago and it should have been taken care of when it happened and that's all I am going to say about that.</p> <p>During an interview on 04/08/24 at 12:41 PM, Certified Nursing Assistant (CNA)2 revealed that she was in the B wing day room cleaning and picking up breakfast trays when she heard License Practical Nurse (LPN)1 say, keep this f***** door shut. After hearing what LPN1 said she left the day room and went down the B wing hall and she saw the unit manager coming up the hall from the opposite direction. CNA2 stated that R1 was COVID positive and the only resident residing in that room at the time and the nurse had been telling him to keep the door closed. CNA2 stated that LPN1 was usually good with everyone, and she was not sure of what happened that day. CNA2 explained that she did not report the incident because the unit manager was already in the hallway.</p> <p>During an interview on 04/08/24 at 12:59 PM, CNA1 revealed that she was helping gather the breakfast trays on hall B when she saw LPN1 at R1's doorway and heard LPN1 yell when I tell you to keep the f***** door closed, I mean keep the f***** door closed. LPN1 then walked away and went to R2's room and then I heard him say something about respecting him. CNA1 confirmed that R1 was in the room alone. CNA1 stated that Registered Nurse (RN)1 and the staffing development coordinator were in the area as well.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/08/24 at 1:23 PM, LPN1 revealed that R1 was Covid positive but refused to keep his door closed. LPN1 explained that R1 expressed to him that he didn't like to be in his room or have his door closed and he expressed to the resident he understood but explained to him what the policy stated. LPN1 stated R1 needed to stay in his room to keep others safe. LPN1 further stated that he told a unit manager what R1 had expressed to him related to being in his room with the door shut. LPN1 stated R1 came at him and LPN1 stated to him, I will keep closing the f***** door. LPN1 stated, I did speak inappropriately, and I take ownership for what I said. LPN1 then revealed that R2 sent a message to him by a CNA saying, tell the nurse to bring me my g** d*** medicine. LPN 1 revealed that when he entered R2's room, he stated to R2, You are not going to talk to me like I am a d*** child. LPN1 stated I did speak inappropriately, I did say what I said to each of them and I take ownership for what I said.</p> <p>During an interview on 04/08/24 at 2:49 PM, the Administrator revealed that she was notified by the staffing development coordinator as soon as I entered the door. She informed me that LPN1 had flipped out. The staffing development coordinator informed me that they found LPN1 in R2's room and she and RN1 removed him from the room. The Administrator stated they interviewed LPN1 and he stated that he hadn't been sleeping well and he was exhausted, and his nerves were on edge. LPN1 admitted that he should not have reacted the way he did. The Administrator suspended him immediately. He only came back to the building when we called him in to terminate him. The Administrator stated that it's her expectation that all staff treat the residents with dignity, be courteous, be polite and regardless of what the resident is saying and doing to them to make sure the resident is safe. The Administrator states that she has zero-tolerance for abuse and above all else staff is to keep the residents safe.</p>		