STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425172	A. Building B. Wing	07/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Manor - Greenwood	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 38293 Based on interview, record review, and facility policy review, the facility failed to ensure staff notified the resident's physician and/or the resident's responsible party (RP) of a fall for 2 (Resident (R)1 and R3) of 3 sampled residents reviewed for falls. Findings include: Review of a facility policy titled, Fall Management, revised on 05/05/23, revealed, 8. The physician and family are promptly notified, and an incident report is completed. Review of a Resident Face Sheet revealed the facility admitted R1 on 11/03/23. According to the Resident Face Sheet, R1 was admitted to the facility with diagnoses including but not limited to: altered mental status, abnormalities of gait and mobility, muscle wasting and atrophy, unsteadiness on feet, muscle weakness, lack of coordination, hemiplegia and hemiparesis (muscle weakness on one side of the body) following a cerebral infarction (stroke) affecting the left non-dominant side, dementia, and cognitive communication deficit. Review of a Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/05/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated the resident had severe cognitive impairment. Review of R1's Care Plan included a problem statement initiated on 11/14/23 that indicated the resident was at risk for falls as evidenced by physical impairment with left-sided weakness, unsteady gait, and muscle weakness. Review of a Falls Investigation Worksheet, dated 05/29/24, revealed R1 had an unwitnessed fall on 05/25/24 at 6:00 AM. The worksheet revealed the resident took themselves to the restroom unassisted. The worksheet revealed the box indicating whether the resident's physician was notified was unchecked. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425172	A. Building B. Wing	07/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Manor - Greenwood	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R1's Resident Progress Notes, dated 05/25/24 at 6:03 PM and written by Licensed Practical Nurse (LPN)3, revealed the resident was heard yelling from their room for help. A caregiver went to assist and reported the resident was on the floor. The note revealed the resident stated they were attempting to take themselves to the restroom. The note revealed the fall was unwitnessed, vital signs were taken, and the incident was reported to the RP. The note did not reveal that the resident's physician was notified of the fall. During an interview on 07/27/24 at 9:24 AM, LPN3 stated the time of the fall on the Falls Investigation Worksheet for the fall on 05/25/24 was incorrect and the fall occurred during her shift at 6:00 PM. LPN3 stated that she documented the fall in R1's progress notes. LPN3 stated she could not remember if she notified the resident's physician and that she would have documented it in the resident's progress note. Review of a Falls Investigation Worksheet, dated 06/04/24, revealed R1 had an unwitnessed fall on 05/28/24 at 4:35 AM. The worksheet revealed the box indicating whether the resident's physician was notified was unchecked. Review of R1's Resident Progress Notes, dated 05/28/24 at 5:49 AM, revealed the resident was yelling out help me. The note revealed the nurse discovered the resident on the floor in the entry way of their room. The note revealed the on-call nurse, the Director of Nursing (DON), and the family were notified. The note did not reveal that the resident's physician was notified of the fall. Review of an undated Falls Investigation Worksheet revealed R1 had a witnessed fall on 06/02/24 at 2:00 AM. The worksheet revealed the box indicating whether the resident's physician and RP were notified was unchecked. Review of R1's Resident Progress Notes dated 06/02/24 revealed no documentation by staff to indicate that the resident's physician and RP were notified of the resident's fall on 06/02/24 at 2:00 AM. R1's Resident Progress Notes dated 06/02/24 at 7:30 PM, revealed that the resident had a large purple/black discoloration on their left hip. The resident complained of pain and the family wanted the resident sent to the emergency room for an x-ray. The note revealed the on-call nurse and medical doctor were notified, and emergency medical services were called to transport the resident. During an interview on 07/26/24 at 2:51 PM, the DON stated that she reviewed the Falls Investigation Worksheet and the Resident Progress Notes for R1 for the resident's falls on 05/25/24, 05/28/24, and 06/02/24. The DON stated the staff failed to notify the resident's physician and/or RP of the resident's falls. 2. Review of a Resident Face Sheet revealed the facility admitted R3 on 03/14/22, with diagnoses including but not limited to: cerebral infarction (stoke), dementia, muscle wasting and atrophy, history of falling, cognitive communication deficit, unsteadiness on feet, other abnormalities of gait and mobility, and muscle weakness. Review of a Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/21/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 0 out of 15, which indicated the resident had severe cognitive impairment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425172	A. Building B. Wing	07/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Manor - Greenwood	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R3's Care Plan included a problem statement initiated on 03/25/22, that indicated the resident was at risk for falls as evidenced by unsteady gait and muscle weakness. Review of an undated Falls Investigation Worksheet revealed R3 had an unwitnessed fall on 06/30/24 at 4:30 AM. The worksheet revealed the box indicating whether the resident's physician and RP were notified was unchecked. Review of R3's Resident Progress Notes dated 06/30/24 revealed no documentation by staff to indicate that the resident's physician and RP were notified of the resident's fall on 06/30/24 at 4:30 AM. The Resident Progress Notes dated 06/30/24 at 10:05 PM, revealed the resident was sent to the emergency room upon the start of the shift due to a verbalized fall from the off-going nurse and the resident's RP wanted the resident sent out to the hospital for an evaluation due to the resident complaining of back pain. Review of a Complaint/Grievance Roll-Up report for the timeframe from 07/01/24 through 07/26/24 revealed that on 06/30/24, R3's RP reported a grievance related to fall notification. During an interview on 07/27/24 at 8:02 AM, the Administrator stated the nurse that worked on 06/30/24 at the time of R3's fall was Registered Nurse (RN)4. The DON stated that RN4 did not notify the resident's representative or the resident's physician of the resident's fall. The Administrator stated RN4 said she had passed the information along to the first shift nurse to report. The Administrator stated she spoke with the nurse that received the report from RN4 and confirmed that the nurse who received the report did not report the fall to the resident's RP or physician. During a telephone interview on 07/27/24 at 10:02 AM, the Nurse Practitioner (NP) stated that they relied on the nurses to notify the provider when a resident had a fall. The NP stated she worked at the facility every Monday through Friday and was on call. The NP further stated on the weekends and during the times that she was off there was an on-call provider service available for the nurses to call and report falls to a provider. During a telephone interview on 07/27/24 at 10:30 AM, the Medical Director (MD) stated that it was his expectation that staff notify the provider when a resident had a fall. The MD stated that there was a NP at the facility during the week and there was a 24-hour on call provider service that staff could report falls to. During a follow-up interview on 07/27/24 at 12:29 PM, the Administrator stated the nurse that was on duty during the time of the resident's fall was responsible for notifying the resident's physician and RP. The Administrator stated it was her expectation that the resident's RP and physician were notified after each fall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425172	A. Building B. Wing	07/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Manor - Greenwood	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)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38293 Based on interview, record review, and facility policy review, the facility failed to ensure staff accurately coded a Minimum Data Set (MDS) for 1 (Resident (R)2) of 3 sampled residents reviewed for falls. Findings include: Review of a facility policy titled, Minimum Data Set (MDS), revised on 09/28/23, revealed, A licensed nurse will conduct or coordinate each assessment with the interdisciplinary team. An MDS, which is a comprehensive, accurate, standardized reproducible assessment will be completed for each resident, using the RAI [resident assessment instrument] process. Facility staff complete a comprehensive assessment of each resident's need, strengths, goals, life history, and preferences, and offer guidance for further assessment once problems have been identified. The policy revealed, 1. Review the resident's medical record. This review may include pre-admission activities. Identify resident's status, care and services rendered during the Observation Period for the current assessment. Review is to include, but not be limited to pre-admission, admission, and transfer notes; current plan of care, physicians" orders, progress notes, history and physical; nursing, dietary, activity, social service, and therapy notes and assessments; monthly summaries lab and x-ray reports, consultations, medication administration records, treatment administration records, and resident, staff and family interviews. The policy revealed, 9. Each assessment must represent an accurate picture of the resident's status during the observation period of the MDS. Review of a Resident Face Sheet revealed the facility admitted R2 on 08/05/22, with diagnoses including but not limited to: altered mental status, muscle wasting and atrophy, dementia, and unsteadiness on feet. Review of an undated Falls Investigation Worksheet revealed R2 had an unwitnessed fall on 01/06/24 at 6:30 AM. Review of R2's Resident Progress Notes, dated 01/06/24 at 6:57 AM, revealed the resident was observed on the floor beside their bed with no injury present. Review of a quarterly MDS, with an Assessment Reference Date (ARD) of 03/17/24, revealed the MDS was not coded to reflect the resident had sustained a fall with no injury since their prior assessment. During an interview on 07/26/24 at 1:59 PM, the Care Coordinator (CC) stated she reviewed R2's medical record and the resident fell on [DATE] and it should have been documented on the resident's quarterly MDS with the ARD of 03/17/24. The CC stated that when coding the falls section of the quarterly MDS with the ARD of 03/17/24, she did not review R2's falls investigation worksheets, but she did review the progress notes and missed that R2 had a fall on 01/06/24. During an interview on 07/27/24 at 12:29 PM, the Administrator stated that it was her expectation that MDS assessments were accurate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425172	A. Building B. Wing	07/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Manor - Greenwood	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)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 38293 Based on interview, record review, and facility policy review, the facility failed to ensure resident care plans were updated to include revised appropriate fall interventions for 3 (Residents (R)1, R2, and R3) of 3 sampled residents reviewed for falls. Findings include: Review of a facility policy titled, Fall Management, revised on 05/05/23, revealed, 6. The care plan reflects individualized interventions that are reassessed and revised as needed. Review of a facility policy titled, Care Plan Process, Person-Centered Care, revised on 05/05/23, revealed, 9. Thru ongoing assessment, the facility will initiate person-centered care plans when the resident's clinical status or change of condition dictates the need such as but not limited to falls and pressure ulcer development. 1. Review of a Resident Face Sheet revealed the facility admitted R1 on 11/03/23, with diagnoses including but not limited to: altered mental status, abnormalities of gait and mobility, muscle wasting and atrophy, unsteadiness on feet, muscle weakness, lack of coordination, hemiplegia and hemiparesis (muscle weakness on one side of the body) following a cerebral infarction (stroke) affecting the left non-dominant side, dementia, and cognitive communication deficit. Review of a Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/05/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated the resident had severe cognitive impairment. The MDS revealed the resident had two or more falls with no injury and one fall with an injury since their prior assessment. Review of R1's Care Plan included a problem statement initiated on 11/14/23, that indicated the resident was at risk for falls as evidenced by physical impairment with left-sided weakness, unsteady gait, and muscle weakness. Interventions directed staff to use a bed alarm for monitoring the resident to prevent falls (initiated 06/27/24), place a chair alarm to the resident's chair to alert staff when the resident is attempting to exit the chair unassisted (initiated (06/23/24), instruct the resident to request assistance or supervision while ambulating for safety and reduce fall risk (initiated 03/07/24), provide adequate lighting and ensure areas are free of clutter (initiated 11/14/23), provide prompt assistance (initiated 11/14/23), ensure the call light is within reach and answer promptly (initiated 11/14/23), encourage activities and socialization (initiated 11/14/23), encourage the resident to ask for assistance from the staff (initiated 11/14/23), and have therapy evaluate and treat the resident per the resident's orders (initiated 11/14/23). Review of a Falls Investigation Worksheet, dated 05/20/24, revealed R1 had an unwitnessed fall on 05/25/24 at 6:00 AM. The worksheet revealed the resident had no injuries. The worksheet revealed recommended interventions were to request an evaluation for placement of a bed and chair alarm due to confusion and impulsiveness and to increase staff rounding to address the resident's need for toileting. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425172	A. Building B. Wing	07/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Manor - Greenwood	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)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Falls Investigation Worksheet, dated 06/04/24, revealed R1 had an unwitnessed fall on 05/28/24 at 4:35 AM. The worksheet revealed the resident had no injuries. The worksheet revealed recommended interventions were to increase staff rounds to every 30 to 60 minutes, to initiate a toileting program, and to evaluate for the placement of a chair and bed alarm. Review of an undated Falls Investigation Worksheet, revealed R1 had a witnessed fall on 06/02/24 at 2:00 AM. The worksheet revealed the resident had no injuries. However, an Emergency Department Note, dated 06/02/24, revealed the resident had a 7.0 centimeter (cm) in length by 5.5 cm in width subcutaneous hematoma on their left hip. The Falls Investigation Worksheet revealed that it was unknown what the resident was attempting to do at the time of the fall and that the resident was standing up with their hand on the wall. The worksheet revealed interventions included the resident was provided care and then assisted to the dayroom next to the nursing station, and staff provided the resident with food and drink. Review of a Five-Day Follow-Up Report, dated 06/07/24, revealed interventions by the facility to prevent future injury included continuing occupational and physical therapy as appropriate and for the resident to be evaluated by the psychiatric physician's assistant at their next visit on 06/05/24. Review of R1's Resident Progress Notes, dated 07/09/24, revealed the resident was found on the floor by their bed, on their knees. The note revealed the resident stated they were trying to go to the bathroom. The note revealed no obvious injuries were noted. Review of a Falls Investigation Worksheet, dated 07/20/24, revealed R1 had an unwitnessed fall on 07/18/24 at 4:40 PM. The worksheet revealed the resident had no injuries. The worksheet revealed recommended interventions included daily checks of the bed and chair alarms for function and placement. During an interview on 07/26/24 at 1:59 PM, the Care Coordinator (CC) stated that she was responsible for updating the resident care plans. The CC stated that falls were discussed weekly with the interdisciplinary team (IDT). The CC stated the interventions that were on the Falls Investigation Worksheet were interventions that were immediately placed or recommendations for the team to discuss. The CC further stated she only updated the care plan when she was instructed to do so and for R1's falls on 05/25/24, 05/28/24, 06/02/24, 07/09/24, and 07/18/24. The CC concluded she was not instructed to update the care plan even though interventions were put in place. 2. Review of a Resident Face Sheet revealed the facility admitted R2 on 08/05/22, with diagnoses including but not limited to: altered mental status, muscle wasting and atrophy, dementia, and unsteadiness on feet. Review of a Quarterly MDS, with an ARD of 03/17/24, revealed a Staff Assessment for Mental Status (SAMS) determined R2 had short and long-term memory problems and severely impaired cognitive skills for daily decision making. The MDS revealed the resident was rarely/never understood and rarely/never understood others. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425172	A. Building B. Wing	07/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Manor - Greenwood	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)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R2's Care Plan included a problem statement initiated on 08/18/22, that indicated the resident was at risk for falls as evidenced by cognitive impairment, muscle weakness/wasting, physical impairment, and unsteady gait. Interventions directed staff to apply bolsters to the resident's bed to define the perimeter of the bed (initiated 06/14/24), ensure the bed is low and a fall mat to floor (initiated 09/21/22), provide adequate lighting and ensure areas are free of clutter (initiated 08/19/22), provide prompt assistance (initiated 08/19/22), ensure the call light is within reach and answered promptly (initiated 08/19/22), encourage activities and socialization per guidelines (initiated 08/19/22), and encourage the resident to ask for assistance from staff (initiated 08/19/22). Review of an undated Falls Investigation Worksheet, revealed R2 had an unwitnessed fall on 01/06/24 at 6:30 AM. The worksheet revealed the resident had no injury. The worksheet revealed that another resident had attempted to assist R2 in ambulation and was reeducated on R2's inability to ambulate. Review of an undated Falls Investigation Worksheet revealed R2 had an unwitnessed fall on 07/24/24 at 5:15 PM. The worksheet revealed the resident had no injury. The worksheet revealed that the recommended interventions were to re-educate staff on making frequent rounds for safety. During an interview on 07/26/24 at 1:59 PM, the Care Coordinator (CC) stated that she was responsible for updating the resident care plans. The CC stated that falls were discussed weekly with the interdisciplinary team (IDT). The CC stated the interventions that were on the Falls Investigation Worksheet were interventions that were immediately placed or recommendations for the team to discuss. The CC further stated she only updated the care plan when she was instructed to do so and for R2's falls on 01/06/24 and 07/24/24, she was not instructed to update the care plan even though interventions were put in place. During an interview on 07/26/24 at 2:40 PM, Certified Nursing Assistant (CNA)5 stated that she worked with R2 frequently. CNA5 stated that R2 was not able to use the call light or understand others so interventions that encouraged the use of the call light and the resident to ask for assistance from staff were inappropriate. CNA5 stated that an intervention that was implemented by the nursing staff after the resident's last fall was to keep the resident in high visibility areas throughout the day to monitor the resident. CNA5 stated that the CNAs had access to the care plans but a lot of the interventions that were implemented were not on the care plan. CNA5 stated R2's fall interventions were passed down from the nurses and from the CNAs during their meetings at shift change. CNA5 stated there were a lot of agency staff that worked at the facility, and it was hard for the agency staff to keep up with the interventions if the interventions were not documented on the care plan. 3. Review of a Resident Face Sheet revealed the facility admitted R3 on 03/14/22, with diagnoses including but not limited to: cerebral infarction (stoke), dementia, muscle wasting and atrophy, history of falling, cognitive communication deficit, unsteadiness on feet, other abnormalities of gait and mobility, and muscle weakness. Review of a Quarterly MDS, with an ARD of 06/21/24, revealed the resident had a BIMS score of 0 out of 15, which indicated the resident had severe cognitive impairment. The MDS revealed the resident had one fall with injury since their prior assessment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425172	A. Building B. Wing	07/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Manor - Greenwood	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)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R3's Care Plan included a problem statement initiated on 03/25/22, that indicated the resident was at risk for falls as evidenced by unsteady gait and muscle weakness. Interventions directed staff to remind the resident to lock their wheelchair when they are going to stand up for safety precautions (initiated 03/12/24), provide adequate lighting and areas are free of clutter (initiated 03/25/22), anticipate the resident's needs and provide prompt assistance (initiated 03/25/22), ensure the call light is within reach and answered promptly (initiated 03/25/22), entourage activities and socialization (initiated 03/25/22), encourage the resident to ask for assistance from staff (initiated 03/25/22), and have therapy evaluate and treat the resident per orders (initiated 03/25/22). Review of an undated Falls Investigation Worksheet revealed R3 had a witnessed fall on 06/12/24 at 7:15 PM. The worksheet revealed the resident had a skin tear to their left elbow. The worksheet revealed recommended interventions included for staff to try and keep the resident occupied at all times to help with the resident's wandering, the resident will continue wearing slip-resistant socks, the resident was educated on not standing alone, and therapy was consulted. During an interview on 07/26/24 at 1:59 PM, the Care Coordinator (CC) stated that she was responsible for updating the resident care plans. The CC stated that falls were discussed weekly with the interdisciplinary team (IDT). The CC stated the interventions that were on the Falls Investigation Worksheet were interventions that were immediately placed or recommendations for the team to discuss. The CC further stated she only updated the care plan when she was instructed to do so and for R3's fall on 06/12/24, she was not instructed to update the care plan even though interventions were put in place. During an interview on 07/26/24 at 2:51 PM, the Director of Nursing (DON) stated that care plans were updated by the CC. The DON stated fall interventions were discussed during their weekly meetings and the CC should be updating the care plan with the interventions that had been implemented. The DON stated she did not review the care plans to ensure interventions were updated. During an interview on 07/27/24 at 12:29 PM, the Administrator stated that the facility took a team approach to determining what fall interventions were appropriate. The Administrator stated falls were discussed weekly and appropriate interventions for those falls were determined by the IDT, and the CC was responsible for updating the care plan with those interventions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425172	A. Building B. Wing	07/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Manor - Greenwood	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 38293 Based on interview, record review, and facility policy review, the facility failed to ensure staff followed the facility policy for fall management and conducted neurological evaluations and post fall nursing documentation for 72 hours for 3 (Residents (R)1, R2, and R3) of 3 sampled residents reviewed for falls. Findings include: Review of a facility policy titled, Fall Management, revised on 05/05/23, revealed, 7. Neurological evaluations will be performed for a resident who sustains an unwitnessed fall, regardless of the resident's cognitive status at the time of the incident. The policy revealed, 9. Post fall nursing documentation for 72 hours, every shift will be completed to monitor the development of late effect or complications of the fall. Review of a facility policy titled, Neurological Checks (Neuro Checks), revised 05/05/23, revealed, The licensed nurse will perform neurological checks following any type of actual or suspected head injury of for changes in level of consciousness. The policy revealed, 1. Neurological checks are performed following an actual or suspected head injury or change in level of consciousness per physician ordered frequencyOR [sic]: A. Initially, then B. Every 15 minutes for 1 hour, then C. Every 30 minutes for 2 hours, then D. Every 1 hour for 2 hours, then E. Every shift for 72 hours. The policy revealed, 3. Documentation is completed on the Neurological Evaluation Flow Sheet, via the Glasgow Coma Scale. Follow directions on the form and reference for accurate scoring. 1. Review of a Resident Face Sheet revealed the facility admitted R1 on 11/03/23, with diagnoses including but not limited to: altered mental status, abnormalities of gait and mobility, muscle wasting and atrophy, unsteadiness on feet, muscle weakness, lack of coordination, hemiplegia and hemiparesis (muscle weakness on one side of the body) following a cerebral infarction (stroke) affecting the left non-dominant side, dementia, and cognitive communication deficit. Review of a Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/05/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated the resident had severe cognitive impairment. The MDS revealed the resident had two or more falls with no injury and one fall with an injury since the resident's prior assessment. Review of R1's Care Plan included a problem statement initiated on 11/14/23 that indicated the resident was at risk for falls as evidenced by physical impairment with left-sided weakness, unsteady gait, and muscle weakness. Review of R1's Active Orders revealed an order with a start date of 11/03/23 that indicated the resident was at risk for falls, elopement, and wandering. Review of R1's Resident Progress Notes, dated 05/25/24 at 6:03 PM, revealed the resident was heard yelling from their room for help. The note revealed the caregiver went to assist the resident and reported the resident was on the floor. The note revealed the resident had an unwitnessed fall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425172	A. Building B. Wing	07/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Manor - Greenwood	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Neurological Evaluation Flow Sheet for R1's fall on 05/25/24, revealed that staff did not complete the pupils, reflexes, and movement sections of the flow sheet for 05/25/24 at 6:00 PM through 05/25/24 at 11:00 PM. The flow sheet revealed that staff did not complete the vital signs section of the flow sheet on the second and third shift on 05/26/24 and the first shift on 05/27/24. Review of R1's Resident Progress Notes revealed that staff did not document post-fall nursing documentation on every shift for 72 hours after the fall on 05/25/24. Review of a Falls Investigation Worksheet, dated 06/04/24, revealed the resident had an unwitnessed fall on 05/28/24 at 4:35 AM. Review of R1's medical record revealed no documented evidence that neurological evaluations were performed after the unwitnessed fall on 05/28/24. Review of R1's Resident Progress Notes revealed that staff did not document post-fall nursing documentation on every shift for 72 hours after the fall on 05/28/24. Review of a Falls Investigation Worksheet, dated 06/24/24, revealed the resident had an unwitnessed fall on 06/23/24 at 4:30 PM. Review of a Neurological Evaluation Flow Sheet for the resident's fall on 06/23/24 revealed that staff did not complete the vital signs section of the flow sheet on 06/23/24 at 5:30 PM and 06/23/23 at 10:30 PM. The flow sheet revealed that staff did not complete the movement section of the flow sheet on 06/23/24 at 10:30 PM through 06/24/24 at 5:30 AM. Further review revealed the last documented neurological evaluation was on 06/24/24 at 5:30 AM. There was no documentation to show that staff completed the neurological evaluations on every shift for 72 hours. Review of an undated Falls Investigation Worksheet revealed the resident had an unwitnessed fall on 06/27/24 at 4:45 AM. Review of R1's medical record revealed no documented evidence that neurological evaluations were performed after the unwitnessed fall on 06/27/24. Review of R1's Resident Progress Notes, dated 07/09/24, revealed the resident was found on the floor by their bed, on their knees. The note revealed the resident stated they were trying to go to the bathroom. The note revealed no obvious injuries were noted. Review of R1's Resident Progress Notes revealed that staff did not document post-fall nursing documentation on every shift for 72 hours after the fall on 07/09/24. 2. Review of a Resident Face Sheet revealed the facility admitted R2 on 08/05/22, with diagnoses including but not limited to: altered mental status, muscle wasting and atrophy, dementia, and unsteadiness on feet. Review of a Quarterly MDS, with an ARD of 03/17/24, revealed a Staff Assessment for Mental Status (SAMS) determined R2 had short and long-term memory problems and severely impaired cognitive skills for daily decision making. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425172	A. Building B. Wing	07/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Manor - Greenwood	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R2's Care Plan included a problem statement initiated on 08/18/22, that indicated the resident was at risk for falls as evidenced by cognitive impairment, muscle weakness/wasting, physical impairment, and unsteady gait. Review of an undated Falls Investigation Worksheet revealed R2 had an unwitnessed fall on 01/06/24 at 6:30 AM. Review of R2's medical record revealed no documented evidence that neurological evaluations were performed after the unwitnessed fall on 01/06/24. Review of R2's Resident Progress Notes revealed that staff did not document post-fall nursing documentation on every shift for 72 hours after the fall on 01/06/24. Review of a Falls Investigation Worksheet, dated 06/14/24, revealed R2 had an unwitnessed fall on 06/14/24 at 12:25 AM. Review of R2's Resident Progress Notes, dated 06/14/24 at 12:56 AM, revealed the resident was sent to the emergency room . Review of R2's Resident Progress Notes, dated 06/14/24 at 6:31 AM, revealed the resident returned from the hospital. Review of R2's medical record revealed no documented evidence that neurological evaluations were performed after the resident had returned from the hospital on 06/14/24 at 6:31 AM. Review of R2's Resident Progress Notes revealed that staff did not document post-fall nursing documentation on every shift for 72 hours after the fall on 06/14/24. Review of an undated Falls Investigation Worksheet revealed R2 had an unwitnessed fall on 07/24/24 at 5:15 PM. Review of R2's medical record revealed no documented evidence that neurological evaluations were performed after the unwitnessed fall on 07/24/24. 3. Review of a Resident Face Sheet revealed the facility admitted R3 on 03/14/22, with diagnoses including but not limited to: cerebral infarction (stroke), dementia, muscle wasting and atrophy, history of falling, cognitive communication deficit, unsteadiness on feet, other abnormalities of gait and mobility, and muscle weakness. Review of a Quarterly MDS, with an ARD of 06/21/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 0 out of 15, which indicated the resident had severe cognitive impairment. The MDS revealed the resident had one fall with injury since their prior assessment. Review of R3's Care Plan included a problem statement initiated on 03/25/22, that indicated the resident was at risk for falls as evidence by unsteady gait and muscle weakness. Review of an undated Falls Investigation Worksheet revealed R3 had an unwitnessed fall on 03/12/24 at 1:30 PM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425172	A. Building B. Wing	07/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Manor - Greenwood	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R3's medical record revealed no documented evidence that neurological evaluations were performed after the unwitnessed fall on 03/12/24. Review of R3's Resident Progress Notes revealed that staff did not document post-fall nursing documentation on every shift for 72 hours after the fall on 03/12/24. During an interview on 07/26/24 at 12:53 PM, Unit Manager (UM)2 stated when a resident had a fall the nurses were to complete a fall packet, which included the Falls Investigation Worksheet. UM2 stated the nurses would then put the packet in a folder at the nurse's station for him to review. UM2 stated he made sure the fall was documented on the 24-hour nurses' report. UM2 stated he did not complete audits to ensure that the nurses completed the neurological evaluations after unwitnessed falls or post fall nursing documentation on every shift for 72 hours after the resident had a fall. UM2 stated he was new to the UM position; he started in the position in December 2023 and was still learning the process for falls. UM2 further stated he made sure the fall investigation was completed and the recommendations for interventions were put on the Falls Investigation Worksheet. He stated he believed the Director of Nursing (DON) was responsible for ensuring the nurses completed the neurological evaluations after unwitnessed falls and post-fall documentation on every shift for 72 hours after the resident had a fall. During an interview on 07/26/24 at 2:51 PM, the Assistant Director of Nursing (ADON) stated that the facility used a lot of agency nurses, and it was difficult to get the agency nurses to document as they should. The ADON stated that she received the fall packets that included the fall investigation but did not audit the fall packet to verify if the nurses had completed the neurological examinations after unwitnessed falls or post-fall nursing documentation on every shift for 72 hours after the resident had a fall. The ADON stated that it was the responsibility of the Unit Managers to ensure the nurses were completing those tasks. During an interview on 07/26/24 at 4:12 PM, UM1 stated that she started in her position as the UM three to four months ago. UM1 stated she was responsible for completing the Falls Investigation Worksheet. UM1 stated that she had noticed that the nurses were not completing the post-fall documentation on every shift for 72 hours after the resident had a fall and had been trying to remind the nurses to complete their documentation. UM1 stated that she did not complete record reviews to verify if the nurses had completed the neurological evaluations after unwitnessed falls. During an interview on 07/27/24 at 8:30 AM, the DON stated that after reviewing the falls of R1, R2, and R3 since December 2023, the DON determined nursing staff had not been completing neurological evaluations and post-fall documentation per the facility's policy. The DON stated that it was the responsibility of the UM to ensure that the tasks outlined in the Fall Management policy were completed. During an interview on 07/27/24 at 10:02 AM, the Nurse Practitioner (NP) stated she expected the nurses to complete neurological evaluations per the facility policy for unwitnessed falls. She stated it was important to monitor the resident after an unwitnessed fall since it was unknown if they hit their head; the neurological evaluations would help to monitor for latent injuries. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425172	A. Building B. Wing	07/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Manor - Greenwood	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/27/24 at 12:29 PM, the Administrator stated it was her understanding that the Unit Managers were responsible for checking the completion of the tasks outlined in the Fall Management policy, and if they were not completed, the Unit Managers were to follow up with the nurse that failed to complete the task.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425172	A. Building B. Wing	07/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Manor - Greenwood	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 38293 Based on interview, record review, and facility policy review, the facility failed to ensure staff conducted fall risk assessments and accurately coded fall risk assessments for 3 (Residents (R)1, R2, and R3) of 3 sampled residents reviewed for falls. Findings include: Review of a facility policy titled, Fall Management, revised on 05/05/23, revealed, 1. Qualified staff evaluates all patient/residents for fall risk at a minimum upon admission, quarterly, with a significant change, and post-fall. 2. The Fall Risk Evaluation assist in identifying the appropriate preventative interventions that will be recorded on the patient/resident's care plan. 1. Review of a Resident Face Sheet revealed the facility admitted R1 on 11/03/23, with diagnoses including but not limited to: altered mental status, abnormalities of gait and mobility, muscle wasting and atrophy, unsteadiness on feet, muscle weakness, lack of coordination, hemiplegia and hemiparesis (muscle weakness on one side of the body) following a cerebral infarction (stroke) affecting the left non-dominant side, dementia, and cognitive communication deficit. Review of a Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/05/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated the resident had severe cognitive impairment. Review of R1's Care Plan included a problem statement initiated on 11/14/23, that indicated the resident was at risk for falls as evidenced by physical impairment with left-sided weakness, unsteady gait, and muscle weakness. Review of a Falls Investigation Worksheet, dated 05/29/24, revealed R1 had an unwitnessed fall on 05/25/24 at 6:00 AM. The worksheet revealed the resident had no injuries. Review of a Falls Investigation Worksheet, dated 06/04/24, revealed R1 had an unwitnessed fall on 05/28/24 at 4:35 AM. The worksheet revealed the resident had no injuries. Review of an undated Falls Investigation Worksheet revealed R1 had a witnessed fall on 06/02/24 at 2:00 AM. The worksheet revealed the resident had no injuries. However, an Emergency Department Note, dated 06/02/24, revealed the resident had a 7.0 centimeter (cm) in length by 5.5 cm in width subcutaneous hematoma on their left hip. Review of a Falls Investigation Worksheet, dated 06/24/24, revealed R1 had an unwitnessed fall on 06/23/24 at 4:30 PM. The worksheet revealed the resident had no injuries. Review of an undated Falls Investigation Worksheet revealed R1 had an unwitnessed fall on 06/27/24 at 4:45 AM. The worksheet revealed the resident had no injuries. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425172	A. Building B. Wing	07/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Manor - Greenwood	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R1's Resident Progress Notes, dated 07/09/24, revealed the resident was found on the floor by their bed, on their knees. The note revealed the resident stated they were trying to go to the bathroom. The note revealed no obvious injuries were noted. Review of a Falls Investigation Worksheet, dated 07/20/24, revealed R1 had an unwitnessed fall on 07/18/24 at 4:40 PM. The worksheet revealed the resident had no injuries. Review of R1's Observation History for the timeframe from 12/01/23 through 07/26/24, revealed that a fall risk evaluation was not documented as completed after the resident had sustained a fall on 05/25/24, 05/28/24, 06/02/24, 06/23/24, 06/27/24, 07/09/24, and 07/18/24. 2. Review of a Resident Face Sheet revealed the facility admitted R2 on 08/05/22, with diagnoses including but not limited to: altered mental status, muscle wasting and atrophy, dementia, and unsteadiness on feet. Review of a Quarterly MDS, with an ARD of 03/17/24, revealed a Staff Assessment for Mental Status (SAMS) determined R2 had short and long-term memory problems and severely impaired cognitive skills for daily decision making. Review of R2's Care Plan included a problem statement initiated on 08/18/22, that indicated the resident was at risk for falls as evidenced by cognitive impairment, muscle weakness/wasting, physical impairment, and unsteady gait. Review of an undated Falls Investigation Worksheet revealed R2 had an unwitnessed fall on 01/06/24 at 6:30 AM. The worksheet revealed the resident had no injury. Review of a Falls Investigation Worksheet, dated 06/14/24, revealed R2 had an unwitnessed fall on 06/14/24 at 12:25 AM. The worksheet revealed the resident had a hematoma to their right forehead. Review of an undated Falls Investigation Worksheet revealed R2 had an unwitnessed fall on 07/24/24 at 5:15 PM. The worksheet revealed the resident had no injury. Review of R2's Observation History for the timeframe from 12/01/23 through 07/26/24, revealed that a fall risk evaluation was not documented as completed after the resident had sustained falls on 01/06/24, 06/14/24, and 07/24/24. Additionally, there was no documentation that a fall risk evaluation had been completed quarterly. 3. Review of a Resident Face Sheet revealed the facility admitted R3 on 03/14/22 with diagnoses including but not limited to: cerebral infarction (stoke), dementia, muscle wasting and atrophy, history of falling, cognitive communication deficit, unsteadiness on feet, other abnormalities of gait and mobility, and muscle weakness. Review of a Quarterly MDS, with an ARD of 06/21/24, revealed the resident had a BIMS score of 0 out of 15, which indicated the resident had severe cognitive impairment. Review of R3's Care Plan included a problem statement initiated on 03/25/22, that indicated the resident was at risk for falls as evidenced by unsteady gait and muscle weakness. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425172	A. Building B. Wing	07/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Manor - Greenwood	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an undated Falls Investigation Worksheet revealed R3 had an unwitnessed fall on 03/12/24 at 1:30 PM. The worksheet revealed the resident had a skin tear to their left elbow. Review of an undated Falls Investigation Worksheet revealed R3 had a witnessed fall on 06/12/24 at 7:15 PM. The worksheet revealed the resident had a skin tear to their left elbow. Review of R3's Observation History for the timeframe from 12/01/23 through 07/26/24, revealed that a fall risk evaluation was not documented as completed after the resident had sustained falls on 03/12/24 and 06/12/24. During an interview on 07/26/24 at 2:51 PM, the Assistant Director of Nursing (ADON) stated that the facility used a lot of agency nurses, and it was difficult to get the agency nurses to document as they should. The ADON stated that she received the fall packets, which included the fall investigation, but she did not audit the fall packet to verify if the nurses had completed the fall risk evaluations. The ADON stated that it was the responsibility of the unit managers (UM) to ensure the nurses were completing that task. During an interview on 07/26/24 at 4:08 PM, UM2 stated that he was not aware that the fall risk evaluations had to be completed after every fall. UM2 stated he did not know who was responsible for ensuring the fall risk evaluations were completed. During an interview on 07/26/24 at 4:12 PM, UM1 stated that she started in her position as the UM three to four months ago. UM1 stated she was responsible for completing the Falls Investigation Worksheet. UM1 stated that she did not complete record reviews to verify if the nurses had completed the fall risk evaluations. UM1 stated she was unaware that ensuring the fall risk evaluations were completed by the nurses was her responsibility. During an interview on 07/27/24 at 8:30 AM, the Director of Nursing (DON) stated that after reviewing the falls of R1, R2, and R3 since December 2023, the DON determined nursing staff had not been completing the fall risk evaluations per the facility's policy. The DON stated that it was the responsibility of the UM to ensure that the tasks outlined in the Fall Management policy were completed. During an interview on 07/27/24 at 12:29 PM, the Administrator stated it was her understanding that the UMs were responsible for checking the completion of the tasks outlined in the Fall Management policy and if they were not completed the UMs were to follow up with the nurse that failed to complete the task.