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Form Approved OMB
No. 0938-0391

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	11/08/2024

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 - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 19186 Based on interview, record review, observation and facility policy review, the facility failed to supervise 1 (Resident (R)6) of 3 sampled residents reviewed for accidents. Specifically, the facility failed to supervise R6, who the facility determined was high risk for falls and required staff assistance with showers/bathing, during a shower on 10/06/24. R6 fell from a shower chair when staff left the resident in the shower room unattended and the resident sustained redness to the knees. Findings include: Review of a facility policy titled, Fall Management, revised 05/05/23, indicated, 1. The facility will identify each patient/resident who is at risk for falls and will plan care and implement interventions to manage falls. 2. Qualified staff will complete the Fall Risk Evaluation to determine if patient/resident is a fall risk. 3. The fall management program includes education for staff in creative, functional strategies while recognizing patients/resident's rights and highest practicable level of function. Review of a Resident Face Sheet revealed the facility admitted R6 on 10/04/24. According to the Resident Face Sheet, the resident had a medical history that included diagnoses including but not limited to: chronic obstructive pulmonary disease, urinary tract infection, unsteadiness on their feet, repeated falls, and dependence on supplemental oxygen. The Resident Face Sheet revealed the facility discharged the resident home on 10/06/24, two days after admission. Review of an occupational therapy (OT) Initial Evaluation, dated 10/02/24, (during a hospital admission prior to admission to the facility) revealed R6 had decreased endurance and decreased balance. The OT evaluation revealed that the resident required supervision for static sitting balance (the ability to maintain the body in a specific position) and required contact guard assistance for dynamic sitting balance (the ability to maintain balance while moving the body in a sitting position). The OT evaluation indicated a goal was for R6 to bath with stand by assistance. Review of R6's nursing Resident Progress Notes dated 10/04/24 at 6:04 PM, revealed the facility admitted the resident at 12:21 PM. The notes revealed the resident was alert and responsive, had incontinent episodes, and staff assisted with activities of daily living. Review of R6's Morse Fall Scale, dated 10/04/24, revealed that R6 was high risk for falls. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a PT [Physical Therapy] Discharge Summary for dates of service from 10/04/24 through 10/06/24, revealed R6 was discharged from therapy due to being discharged to the hospital. Per the summary, the resident had muscle wasting and atrophy in the left and right lower leg, was unsteady on their feet, and had repeated falls. Review of R6's Baseline Care Plan, included a problem statement dated 10/04/24, that revealed the resident was a new admission to the facility. Interventions directed staff that the resident was a fall risk and to encourage the resident to use the call light (initiated 10/04/24). Interventions also directed staff to assist the resident with bed mobility, eating, toileting, transfers, and ambulation (initiated 10/04/24). The care plan did not address the level of assistance R6 required for bathing/showers. Review of R6's Resident Profile, indicated the resident was at risk for falls and required assistance with ambulation, transfers, and toileting (started 10/04/24). The Resident Profile did not address the level of assistance the resident required for bathing/showers. Review of a discharge Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/06/24, revealed R6 had modified independence in cognitive skills for daily decision making and had no short-term memory problems per a staff assessment of mental status (SAMS). The MDS revealed the resident required substantial/maximal assistance (the helper did more than half the effort) with showers/bathing. According to the MDS, tub/shower transfers had not been attempted due to medical condition or safety concerns. Review of a nursing Resident Progress Note, dated 10/06/24 at 10:49 AM, revealed Registered Nurse (RN)9 documented that R6 was found on the floor in the shower room at 8:30 AM. The note revealed R6 was laying in front of a shower chair. According to the note, R6 stated that they hit their head but there were no signs of injury. Per the note, R6's knees were red. The note revealed the nurse contacted the Nurse Practitioner (NP) on call, who wanted staff to continue checking the resident's vital signs. The note revealed RN9 called the NP back with vital changes at 10:24 AM. According to the note, RN9 notified the resident's Responsible Party (RP) of the fall and that R6 was being transferred to the emergency department (ED). Review of R6's Neurological Evaluation Flow Sheet revealed on 10/06/24 at 10:00 AM, the resident's blood pressure was 162/74 millimeters of mercury (mm/Hg) (an increase from 123/75 mm/Hg at 9:25 AM) and the resident's pulse rate was 79 beats per minute (bpm) (a decrease from 91 bpm at 9:25 AM). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an undated facility Summary of Investigation report revealed the facility admitted R6 from a hospital for rehabilitation pending restoration of electrical power at home. The report revealed R6 was alert and oriented and per the hospital therapy notes, R6 was ambulatory with a rolling walker, able to stand with minimal assistance, required minimal assistance with bathing/dressing, and was able to feed themselves (The facility's Summary of Investigation did not address that the hospital therapy notes also revealed that the resident required contact guard assistance for dynamic sitting or that a goal for the resident was to provide stand by assistance with bathing). The report revealed R6 had an unwitnessed fall in the community bathroom on 10/06/24, at approximately 8:30 AM, with no observed injuries. Per the report, RN9 notified the resident's family and the NP, who instructed the nurse to monitor R6's vital signs/neurological checks. According to the report, at approximately 10:00 AM, the resident's vital signs reflected a significant increase in systolic blood pressure and decrease in pulse rate. The note revealed that the NP was notified, and orders were obtained to send the resident to the ED for an evaluation. Per the report, ED notes reflected a computed tomography (CT) scan of the resident's head that showed no injury related to the fall. The note revealed the resident's family took the resident home following the ED evaluation as their power had been restored at home. The Summary of Investigation also revealed the facility reeducated the assigned Certified Nursing Assistant (CNA) regarding Shower Room Safety. Review of R6's CT scan results dated 10/06/24, revealed the resident had no fractures and there were no intracranial findings. During an interview on 11/08/24 at 3:14 PM, CNA8 stated that she gave R6 a shower as soon as she came on the 7:00 AM to 3:00 PM shift. CNA8 stated R6 had feces and urine on them and the resident agreed to take a shower. CNA8 stated that R6 could walk and was alert and oriented. CNA8 stated that during the shower, R6 held out their hand for the washcloth and said they wanted to bathe themselves. CNA8 stated that she stepped across the hall to R6's room to get clothing. CNA8 stated that prior to leaving, she asked R6 if it was okay, and they said yes. CNA8 stated she came back to the shower to check on the resident and they were still washing. CNA8 stated she stepped back out to get sheets from a linen cart and tossed them on R6's bed. CNA8 stated when she got back to the shower R6 was sitting on the shower floor with their legs crossed and their head leaning on the wall. CNA8 stated she opened the shower door and called RN9. CNA8 stated that RN9 assessed R6, and there were no injuries. CNA8 stated R6 did not complain of pain. CNA8 stated she and RN9 assisted the resident back to the shower chair, and she finished R6's shower and dressed them. Review of a typed statement dated 10/07/24, and signed by RN9 revealed R6 stated they fell out of the shower chair and was lying on their right side on the rubber mat in front of the shower chair. RN9's statement revealed the resident had reddened knees. During a telephone interview on 11/08/24 at 3:25 PM, RN9 stated that she was passing medications down the hall and saw CNA8 come out of the shower room. RN9 stated that the resident should not have been left in the shower unsupervised. During an observation on 11/08/24 at 5:05 PM, revealed the shower room was across the hallway from the room where R6 resided. An observation of the shower room revealed there were two shower stalls with a call bell in each stall. Shower chairs were also observed in the shower room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/08/24 at 5:51 PM, the Director of Nursing (DON) stated that she expected the resident's preference to be honored, depending on the resident's capability and safety to be in the shower alone. The DON stated she felt that R6 was safe to be in the shower alone. During an interview on 11/08/24 at 6:07 PM, the Administrator stated that it was her expectation that all residents be afforded the opportunity for safe bathing depending on their preference and capabilities.