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	04/20/2026

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure that Resident (R)1 had adequate supervision to prevent a successful elopement on 04/05/2026.On 04/20/26 at 4:25 PM, the survey team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template, informing the facility IJ existed as of 04/05/26. The IJ was related to 42 CFR 483.25 - Freedom from Accidents and Hazards.On 04/20/26 the facility provided an acceptable IJ Removal Plan. On 04/20/26 the survey team, validated the facility's corrective actions and determined the facility put forth due diligence in addressing the noncompliance. The SA is considering this IJ at Past Noncompliance as of 04/07/26. An extended survey was conducted in conjunction with the Complaint Survey for non-compliance at F689, constituting substandard quality of care.Findings include:Review of the facility policy titled, Elopement with a last revision date of 11/01/17, revealed, To safely and timely redirect patients/residents to a safe environment. Review of facility timeline of events dated 04/05/26 revealed:11:30 AM RESIDENT WAS OBSERVED IN ROOM BY HOUSEKEEPER.11:45 AM NURSE OBSERVED RESIDENT PROPELLING HIS WHEELCHAIR ON HIS HALLHEADED FROM HIS ROOM TOWARD THE DINING ROOM.11:55 AM NURSE WENT TO RESIDENT'S ROOM TO GIVE HIM MEDICATION. IT WAS NOTED THAT THE RESIDENT WAS MISSING.12:10 PM A CODE WHITE WAS CALLED. A SEARCH BEGAN IMMEDIATELY OF THE ENTIRE BUILDING INSIDE and OUTSIDE. A LAUNDRY WORKER NOTED THE RESIDENT ACROSS THE STREET FROM THE (FACILITY) BETWEEN A CARDIOLOGIST OFFICE AND A RETINAL SPECIALIST OFFICE. THE RESIDENT AGREED TO COME BACK TO THE FACILITY WITHOUT INCIDENT (HE SAID HE WAS GOING TO 905 [NAME] STREET) HE RETURNED WITH THE RESIDENT AT APPROXIMATELY 12:18 PM. A BODY AUDIT WAS COMPLETED NO INJURY WAS NOTED. A WAUNDERGARD BRACELET WAS APPLIED.Review of R1's medical record revealed diagnoses including but not limited to, urinary tract infection, vascular dementia, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, wandering, other visual disturbances, and pyogenic arthritis.Review of R1's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/19/26, revealed R1 had a BIMS score of 3 out of 15, indicating severe cognitive impairment. Further review revealed the resident had not exhibited any wandering behaviors and the resident does not wear wander/elopement alarm daily. Review of R1's Elopement Risk Assessment on 03/27/25, revealed no score but indicated the resident is low risk for elopement.Review of R1's Progress Note by Social Services Director on 04/05/26 at 12:10 PM, revealed, STAFF NOTED NOT TO BE IN HIS ROOM. CODE WHITE WAS CALLED, AND SEARCH OF FACILITY WAS CONDUCTED. RESIDENT WAS FOUND OUTSIDE OF FACILITY AND CODE WHITE WAS CALLED OFF. RESIDENT HAS NOT BEEN PREVIOUSLY IDENTIFIED AS AN ELOPEMENT RISK. A WANDERGUARD WILL BE PLACED ON RESIDENT FOR HIS SAFETY TO PREVENT POSSIBLE ELOPEMENT. SSD CALLED RP AND ADVISED OF INCIDENT AND NEED FOR WANDERGUARD. RP HAD NO OBJECTIONS TO DEVICE BEING PLACED ON RESIDENT, AS IT'S FOR HIS SAFETY. SSD WILL ADJUST CARE PLAN TO INCLUDE ELOPEMENT/WANDERGUARD.Review of R1's Progress Note by Nurse Practitioner (NP)1 on (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	04/06/26, revealed, He does not make clear why he he was wandering outside or how he got outside. Patient does report that he is interested in going outside again. Wandering guard is noted on his left wrist at the time of this encounter. He is afebrile. VSS. No other concerns expressed by patient or nursing staff at this time. Patient does seem to be more altered at this time compared to visit on 04/01/2026. I will consider this an isolated event and raises concerns for altered or worsening mental status. Patient has not expressed previous behaviors of elopement prior to this encounter. Patient will be checked for urinary tract infection as well as elevated ammonia levels to rule out possible encephalopathy.Attempted interview with Resident Representative (RP) on 04/20/26 at 1:45 PM and 5:15 PM was unsuccessful. Message left on both attempts. No return call. During an interview with Certified Nursing Assistant (CNA)1 on 04/20/26 at 1:50 PM, revealed, I heard the code white and went to look for the resident. I went out the front door and met another aide. We searched the parking lot and close buildings such as the pharmacy and the assisted living building. That is when we seen [laundry staff name] in laundry coming across the street with the resident. [laundry staff name] and the resident were between the Advanced Cardiology office and the building beside it. I took over from [laundry staff name] and pushed the resident in his wheelchair back to the building. I asked him where he was going and he said home, 905 [NAME] Street. He was in no distress. He was ok. He did not fight coming back into the building. I took him to his nurse. I went back to my side of the building. I do not work on that wing.During an interview on 04/20/26 at 2:15 PM, the Director of Social Services revealed, I was manager on duty. It was a regular Sunday. I was doing work in my office when I heard the nurse on B wing call a code white. I checked for the resident up front. I used my key to check in the admissions office, the MDS office and the scheduler/central supply office. Everyone was looking inside. I went out the front door. Staff was looking outside as well. The laundry guy got in his truck and went to the right. I got into my car and went to the left. By the time I got to the end of the property, I saw [laundry staff name] pushing the resident in his wheelchair between the Cardiologist Office and the Retina Specialist Office across the road. [Laundry staff name] pushed the resident in his wheelchair to two CNA's that brought the resident back into the building. A wander guard was applied to resident's left wrist as soon as the resident returned to the building. We check the wander guard every day, every shift. This resident had never exhibited this behavior before.During an interview with CNA2 on 04/20/25 at 2:29 PM, revealed, The nurse was fixing to give him medication. They called a code white. I went out to the parking lot with [CNA name]. [Staff name] the nurse supervisor went out too. Me and [CNA name] walked down to the stop sign. By that time [laundry staff name] was coming back to the building with the resident from across the street. Me and [CNA name] took over and brought the resident back to the building. The resident stated that he was going to 902 [NAME] Street. He was in no distress. He was very calm and talkative.During an interview with the Director of Nursing (DON) on 04/20/26 at an unspecified time, revealed that elopement risk assessments are conducted upon admission, with any change in condition, and when behavioral changes occur. Residents identified as high risk are care planned accordingly and provided with a Wander Gard device worn on the wrist or ankle. All exit doors are equipped with alarms that emit a loud sound when a wander guard - wearing resident approaches. Clinical staff are responsible for monitoring the devices, while maintenance is responsible for door alarm functionality. The DON stated, The nurse went to give [R1] his medication and could not locate him. The usual places that he likes to visit in the afternoon were checked. He could not be located. We called a code white. The staff searched inside and outside for the resident. [Laundry staff name] got in his vehicle and located the resident around the corner. He pushed the resident toward the facility and two CNAs took over and brought resident back into the building. Body audit was completed. Resident was evaluated for a wander guard. Wander guard was placed. He recited an address where he was going which is uncharacteristic for [R1].During an interview with the Licensed Nursing Home Administrator (LNHA) on 04/20/26 at 3:38 PM, revealed R1 frequently self-propelled his wheelchair throughout the facility but had never shown clear exit-seeking behavior. By the time I was notified, it was over and staff had (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	located the resident with no injury. It only took about six minutes.On 04/20/26 the facility provided an acceptable IJ Removal Plan, which included the following:Resident #1 without injury. Head to toe assessment completed on 4/5/26 with no injuries identified.Elopement Risk evaluation completed on resident #1 on 4/5/26 to reflect current status. New interventions include wander guard. Responsible party and provider notified of new interventions and order recieved.Residents at risk for elopement have the potential to be affected.Current residents in the facility had Elopement Risk Observations updated by 4/7/26 by Licensed Nurse. Residents identified as elopement risk were placed in the elopement binder and had care plans and profiles updated by Director of Nursing/Designee by 4/7/26.Clinical Leadership team were reeducated by the Clinical Consultant by 4/6/26 on Elopement including:Completion of Elopement Risk Observation processImplement interventions immediately based on risk identified through Elopement Risk AssessmentFacility Staff were reeducated by the Director of Nursing/Designee by 4/7/26 on Elopement includingIdentifying behaviors indicating elopement or exit seeking and implementing interventions immediatelyAny staff not receiving this education by 4/7/26 will receive prior to their next scheduled shift.New admission elopement risk assessments are being reviewed in Clinical Morning Meeting Monday - Friday by the Director of Nursing/Designee to validate accuracy and interventions validated if indicated. Quarterly Elopement risk assessments will be reviewed weekly following the MDS schedule to validate accuracy and interventions validated if indicated by the Director of Nursing/Designee.Ad Hoc QACPI was held on 4/7/26Medical Director was notified of the incident and plan on 4/7/26 and 4/20/26Results of these audits will be presented in Quality Assurance and Performance Improvement Committee meeting for review and recommendations for 3 months.AOC date: 4/7/26