| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 425172 | A. Building<br>B. Wing | 06/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Magnolia Manor - Greenwood | 1415 Parkway Drive<br>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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of the facility policy, record reviews, and interviews, the facility failed to report to the State Survey Agency an incident that occurred on 03/23/2025. The facility neglected to identify R78 was no longer in the facility, or was her whereabouts known to facility staff.<br><br>Findings include:<br><br>A review of the facility policy titled Abuse, Neglect, Exploitation or Mistreatment with a complete revision date of 11/01/2017 stated, The Facility shall report immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not result in serious bodily injury to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures .<br><br>Review of R78's Face Sheet revealed she was admitted to the facility on [DATE] with diagnoses including but not limited to: muscle wasting and atrophy, and abdominal aortic aneurysm, without rupture.<br><br>Review of R78's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/23/25 revealed a Brief Interview for Mental Status (BIMS) score was not recorded. Further review of the MDS revealed R78 has impairment of the upper extremity on one side, is at risk for falls, and need partial/moderate assistance for sit to stand mobility, to walk 10 feet and walking 50 feet with two turns as not attempted due to medical condition or safety concerns.<br><br>Review of R78's Electronic Medical Record (EMR) did not reveal any documentation reflecting R78 was capable of making her own healthcare decisions.<br><br>Review of the facility's document titled, Release of Responsibility for Leave of Absence did not include any completed documents for R78.<br><br>Review of R78's Nursing- Elopement Risk Observation dated 03/22/25 indicated Does the patient/resident have safe decision-making capabilities?. This question is answered as No.<br><br>(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 |
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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 06/12/25 at 3:51 PM, Licensed Practical Nurse (LPN)2, provided the following account regarding an incident on 03/23/25 involving R78, a newly admitted resident. She stated, At the start of her shift on 03/23/25, another nurse reported to LPN2 that R78 had received her medication and was outside on the front porch with family. The resident was expected to sign the leave of absence log if she left the facility. LPN2 stated that she did not personally see the resident during her shift. Around 7:30 PM to 8:00 PM, during routine rounds, LPN2 noticed that R78 was not in her room. A search was conducted in common areas including the activity rooms, dayroom, dining room, courtyard, and the front parking lot, but R78 was not found. LPN2 attempted to contact both the resident and the resident's representative by phone, but neither answered. LPN2 informed the Director of Nursing (DON) of the situation. The DON advised continuing attempts to contact the resident and representative, with a plan to call again the following day. LPN2 stated that, per her training, when a resident is missing, staff are instructed to contact the family. LPN2 reported that no follow-up was made with her about the incident. Upon reflection, she believed she should have checked for the resident earlier, confirmed who the resident was with, and contacted the police when the resident could not be located.<br><br>During an interview on 06/12/25 at 6:02 PM, the Administrator stated, On the 21st of March, R78 left on Sunday. I believe she was a smoker and wanted to leave because she couldn't smoke. I do know we assessed everyone for smoking on admission. LPN2 did follow up to reach R78. She wasn't a risk for elopement or disappeared. She was at no risk for elopement. She was told she needed to sign herself out and she did not. Someone in the building knew she was going to leave. She said she was going to the store. Our door locks on an automatic lock at 9 PM. Those who are confused, they wear a wanderguard. We tell the residents they have to sign out, we can't make them. We tried to call and the next day the Social Worker attempted to call the family. The Speech Language Pathologist (SLP) saw her on Sunday. I am unsure if the physician was notified.<br><br>During an interview on 06/13/2025 at 09:08 AM, Medical Director stated, I can not confirm or deny my awareness R78 left against medical advice.<br><br>During an interview on 06/13/25 at approximately 01:15 PM the Administrator revealed that upon admission to the facility, the resident was made aware of the facility's policy regarding leaving the facility and acknowledged understanding by signing the admission handbook. During the survey, the Administrator stated that R78 had a BIMS of 14, she was cognitive and she had told staff that she would be leaving to go to the store with family and that the resident had a right to leave. She confirmed it was not reported to the State Survey Agency that the resident did not return. |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility policy, observations, record reviews and interviews, the facility failed to notify Resident (R)7 and R78 or their resident representative (RR) of bedholds, including bed reserve payments 2 of 2 residents.<br><br>Findings include:<br><br>Review of the facility policy titled, Facility's Policy and State Requirements for Temporary Leave Bed-Hold revised 06/2009 revealed If a resident leaves the facility for temporary hospitalization or therapeutic leave, the resident or his/her representative may ask the Facility to hold the resident's bed until the resident is ready to return (bed hold). The resident and/or his/her representative will be given a copy of the Facility's bed-hold policy before the resident actually leaves for his/her temporary leave or hospitalization. In the case of an emergency hospitalization, the bed hold policy may accompany the resident to the hospital or will be given to the resident or his/her legal representative within twenty-four (24) hours of the resident's hospitalization.<br><br>Review of R78's Face Sheet R78 was admitted to the facility on [DATE] with diagnoses including, but not limited to multiple rib fractures, weakness, type 2 diabetes mellitus without complication, and dementia.<br><br>Review of R78's comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/02/2025, revealed R78 had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, which indicated the resident has moderate cognitive impairment.<br><br>Review of 78's Electronic Medical Record (EMR) did not reveal a bed hold notification.<br><br>During an interview on 06/12/25 at 02:10 PM, R78's RR stated, No, I did not receive a call or anything in writing about a bed hold.<br><br>Review of 7's EMR revealed R7 was admitted to the facility on [DATE] with diagnoses including but not limited to: encephalopathy, dysphagia, parkinsonism, chronic respiratory failure with hypoxia, Dementia, and altered mental status.<br><br>Additional record review revealed R7 had the following hospitalizations:<br><br>5/10/24-5/18/24- Bedhold<br><br>1/28/25-1/31/25- Bedhold<br><br>5/23/25-5/28/25- Bedhold<br><br>During an interview on 6/12/25 at 10:49 AM, Registered Nurse (RN)4 stated, We have a form we send with the resident by transport. The nurses call the family to inform them the resident is being sent to the hospital. The DON and business office takes over from there.<br><br>(continued on next page) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 06/12/25 at 01:59 PM, Business Office staff stated, The bed holds are sent out in real time by the nursing department. The Social Worker (SW) is my back up. The admission Department gets a verbal consent from the RR. That is the only way we do it. It is not an actual form we fill out.<br><br>During an interview on 06/16/25 at 12:56 PM, SW stated, I don't have a bedhold for R78. I did not know the notice of transfer is something that I needed to do it.<br><br>During an interview on 06/16/25 at 05:52 PM, the Director of Nursing (DON) stated, The SW handles the bed hold. I did the bed hold in-service with the SW. We became aware she was not sending them out. I am unsure if we told her to do the bed hold. When we found out the bed holds were not getting completed, we put a plan in place to correct the bed hold notifications. I think it wasn't being completed within the last couple of months due to her being a new employee. |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** (2.)<br><br>Based on review of the facility policy, observations, record reviews and interviews, the facility failed to ensure R131 was free from potential accidents, related to smoking on facility grounds for 1 of 4 residents identified for smoking.<br><br>R131 being observed smoking unsafely, on the property of a smoke-free facility on 06/13/2025. On 06/13/2025 at 1:31 PM, the SA presented the Administrator with an IJ template related to this incident.<br><br>On 06/13/2025 at 5:00 PM, the facility presented an acceptable IJ removal plan. Verification of the plan revealed the facility implemented their removal plan as of 06/16/25 at 6:30 PM. The facility remained out of compliance at a lower scope/severity level of D.<br><br>Findings include:<br><br>A review of the facility policy titled, Smoking Policy, Guidelines with a revision date 11/01/2017 states:<br><br>Policy:Facility's Leadership will establish and enforce a specific smoking policy for Facility patients/residents, visitors and employees, outlining the parameters, if any, under which patients/residents, visitors and employees may be permitted to smoke on Facility's property.<br><br>Procedures<br><br>6. ALL patients/residents are prohibited from keeping any type of smoking materials (lighter, matches, cigarettes, etc.) in their rooms or on their person .<br><br>10. Smoking by any person, including, without limitation, patients/residents, employees or visitors, in non-designated areas of the building or on Facility property, is strictly prohibited.<br><br>Review of R131's Face Sheet revealed she was admitted to the facility on [DATE] with diagnoses including but not limited to, chronic obstructive pulmonary disease, nicotine dependence, and cognitive communication deficit.<br><br>Review of R131's admission MDS with an ARD of 06/04/2025 revealed R131 had a BIMS score of 15 out of 15, indicating intact cognitive function.<br><br>During an observation on 06/13/2025 at 07:40 AM, R131 self-propelled in a wheelchair, behind a cement column, in the courtyard. R131 was observed smoking a cigarette.<br><br>During an interview on 06/13/2025 at 07:42 AM, Registered Nurse (RN)2 was asked about R131 smoking in the courtyard. RN2 stated, We are a smoke-free facility. She is not supposed to be smoking.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 06/13/2025 at 08:58 AM, the Nurse Practitioner stated, She is currently on the Nicotine patch. I was not aware of her smoking. I was just informed. The patch is not holding her. I will place her on the lozenges today.<br><br>During an interview on 06/13/2025 at 10:32 AM, Administrator stated, I have spoken with R131 and the resident voluntarily gave me her cigarettes and lighter. I did the education for smoking with her. She will get discharged on Monday. This is a previously planned discharge.<br><br>During an interview on 06/13/2025 at 11:00 AM, Certified Nursing Assistant (CNA)5 stated, I did not know she was a smoker.<br><br>During an interview on 06/13/2025 at 11:05 AM, RN4 stated, I knew she had a Nicotine patch, I didn't know she was a current smoker.<br><br>During an interview on 06/13/2025 at 11:37 AM, R131 stated, I've been smoking for 41 years. I have been smoking since I got here on Wednesday. Alot of people here smoke, they just don't get caught. A pack would last me about a week. Someone would bring me cigarettes. I kept my cigarettes, lighter, and vape in my little bag, and my bag always stays with me. I go out to the courtyard to smoke. None of the staff ever came out there. A lot of people didn't know.<br><br>During an interview on 06/13/2025 at 11:43 AM, the Social Worker (SW) stated, Apparently this morning she was smoking, and our Administrator went out and talked to her and took the cigarettes from her and re-educated her. About 20 mins ago, I saw her vaping and took that away from R131. I wasn't aware that she was smoking prior to today.<br><br>During an interview on 06/13/2025 at 11:49 AM, the Director of Nursing (DON) stated, I was not aware of any smokers prior to today. I'm not sure if she was a tobacco user upon her admission. It is possible that residents smoke when they go out on a leave of absence. We don't routinely ask them upon return from a leave of absence if they have smoking supplies.<br><br>During an observation on 06/13/2025 at 1:15 PM, R131 was observed in the entryway to her room, crying. She stated, I don't know how I am going to be able to go a few more days without smoking anything. I have been smoking for years.<br><br>During a follow-up interview with the Administrator on 06/13/2025 at 1:45 PM, she was made aware of the interview with R131. The Administrator stated they had identified a total of 4 residents in the facility, who currently smoked, however, none had any smoking paraphernalia on their person or in their rooms.<br><br>The facility's removal plan included:<br><br>Resident (R)131 smoking materials were given to the administrator for storage in administrator's office.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Residents currently residing in the facility were asked by facility leadership if they currently are smokers on 06/13/2025. Four residents identified as current smokers. Two of the four declined cessation products and stated that they sign out and leave the premises with their family and smoke off site. The other two residents requested smoking cessation products. One of these residents does not have order or smoking cessation products and will be referred to NP on 06/13/2025 from the provider for smoking cessation product change.<br><br>The Administrator will review on 06/13/2025 with the residents, that have self-identified as smokers, the admission policy including the smoking policy which states the facility is a non-smoking the facility and any smoking materials must be turned into the administrator for storage in administrators' office. RP/family will be notified and requested to pick up.<br><br>Residents who have smoking materials will be asked to turn in those smoking materials to the administrator for storage in administrator's office on 06/13/2025. No residents had smoking materials.<br><br>Smoking Cessation products will be offered to any resident that has identified as a smoker. If they chose to utilize smoking cessation products, the physician will be notified and orders obtained on 06/13/2025.<br><br>Facility staff will be reeducated on 06/13/2025 regarding the Smoking Policy including that the facility is a nonsmoking facility and that smoking residents are prohibited from keeping any type of smoking materials in their rooms or on their persons.<br><br>Any staff not receiving this education by 06/13/2025 will receive prior to working the next scheduled shift. This will be presented in New Hire Orientation and for agency staff.<br><br>The Director of Nursing will randomly interview a minimum of 2 staff and 2 interviewable residents weekly times 4 weeks then monthly for 2 additional months to validate understanding and compliance with the admission and smoking policy.<br><br>Administrator/designee will round in resident rooms 2 times per day for 5 days, then daily for 3 additional weeks then monthly for 2 additional months to validate thru observation and interview that there are no smoking materials in resident's rooms or on their persons.<br><br>Administrator/designee will round in the courtyard 2 times a day for 5 days, then daily for 3 additional weeks then monthly for 2 additional months to validate no smoking is occurring in this area.<br><br>Any concerns will be addressed at time of discovery.<br><br>The Medical Director was notified on 06/13/2025 of the Immediate Jeopardy.<br><br>Ad Hoc quality Assurance Performance Improvement Meeting was held on 06/13/2025 to discuss contents of this plan.<br><br>Administrator will oversee compliance of this plan for three months.<br><br>Based on review of the facility policy, record review, and interviews, the facility failed to ensure that Resident (R)78 was free from elopement from the facility on 03/23/25, at an unknown time.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 06/13/2025 at 1:20 PM the State Agency (SA) determined that the facility's non-compliance with one or more federal health, safety, and/or quality regulations could cause psychosocial harm.<br><br>On 06/13/2025 at 1:21 PM, the survey team provided the Administrator with a copy of the Centers for Medicare and Medicare Services (CMS) Immediate Jeopardy (IJ) Template, informing the facility IJ existed as of 03/23/2025, when Resident (R)78 eloped from the facility. The IJ was related to 42 CFR 483.25 -Quality of Care, related to F689- Free of Accident Hazards/Supervision/Devices.<br><br>On 06/16/2025 at 3:56 PM, the facility provided an acceptable IJ Removal Plan related to R78's elopement. The survey team validated the facility's implementation of the removal plan related to the elopement on 06/16/2025. The IJ was removed and lowered to a scope/severity level of D.<br><br>Findings include:<br><br>Review of the facility's policy titled, Elopement revised 11/01/2017 revealed, To safely and timely redirect patients/residents to a safe environment. A prompt investigation and search will be conducted if a patient/resident is considered missing. The facility will determine a signal code, e.g. Code [NAME] to designate a missing patient/resident.<br><br>Procedures:<br><br>1. Once it has been established that a patient/resident is missing, all employees are notified immediately by paging overhead_____ (insert code name).<br><br>2. The DON/designee completes a missing resident profile.<br><br>4. The entire search process of the facility and grounds, from the time the patient/resident is missing, will be completed within (30) thirty minutes.<br><br>Review of the facility's policy titled, Against Medical Advice (AMA)- Day Outings/Therapeutic Leaves of Absence revised 6/9/2023 revealed Under Procedures: 3. C. If the resident/legal representative still wishes to leave, the facility designee will ask the resident/legal representative to sign the Against Medical Advice Waiver and Release for Day Outings/Therapeutic Leaves of Absence form (Waiver). 1. If the patient/resident can make his/her own healthcare decisions, as documented in the medical record by the treating physician, resident will sign the Waiver.<br><br>Review of R78's Face Sheet revealed she was admitted to the facility on [DATE] with diagnoses including but not limited to; muscle wasting and atrophy, and abdominal aortic aneurysm, without rupture.<br><br>Review of R78's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/23/25 revealed a Brief Interview for Mental Status (BIMS) score was not recorded. Further review of the MDS revealed R78 has impairment of the upper extremity on one side, is at risk for falls, and need partial/moderate assistance for sit to stand mobility, to walk 10 feet and walking 50 feet with two turns as not attempted due to medical condition or safety concerns.<br><br>Review of R78's Electronic Medical Record (EMR) did not reveal any documentation reflecting R78 was capable of making her own healthcare decisions.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of Accuweather.com revealed that on 03/23/25, the high was 57 degrees Fahrenheit and the low was 28 degrees Fahrenheit, in regards to the temperature.<br><br>Review of the facility's document titled, Release of Responsibility for Leave of Absence did not include any completed documents for R78.<br><br>Review of R78's Nursing- Elopement Risk Observation dated 03/22/25 indicated Does the patient/resident have safe decision-making capabilities?. This question is answered as No.<br><br>During an interview on 06/12/25 at 3:51 PM, Licensed Practical Nurse (LPN)2, provided the following account regarding an incident on 03/23/25 involving R78, a newly admitted resident. She stated, At the start of her shift on 03/23/25, another nurse reported to LPN2 that R78 had received her medication and was outside on the front porch with family. The resident was expected to sign the leave of absence log if she left the facility. LPN2 stated that she did not personally see the resident during her shift. Around 7:30 PM to 8:00 PM, during routine rounds, LPN2 noticed that R78 was not in her room. A search was conducted in common areas including the activity rooms, dayroom, dining room, courtyard, and the front parking lot, but R78 was not found. LPN2 attempted to contact both the resident and the resident's representative by phone, but neither answered. LPN2 informed the Director of Nursing (DON) of the situation. The DON advised continuing attempts to contact the resident and representative, with a plan to call again the following day. LPN2 stated that, per her training, when a resident is missing, staff are instructed to contact the family. LPN2 reported that no follow-up was made with her about the incident. Upon reflection, she believed she should have checked for the resident earlier, confirmed who the resident was with, and contacted the police when the resident could not be located.<br><br>During an interview on 06/12/25 at 6:02 PM, the Administrator stated, On the 21st of March, R78 left on Sunday. I believe she was a smoker and wanted to leave because she couldn't smoke. I do know we assessed everyone for smoking on admission. LPN2 did follow up to reach R78. She wasn't at risk for elopement or disappeared. She was at no risk for elopement. She was told she needed to sign herself out and she did not. Someone in the building knew she was going to leave. She said she was going to the store. Our door locks on an automatic lock at 9 PM. Those who are confused, they wear a wanderguard. We tell the residents they have to sign out, we can't make them. We tried to call and the next day the Social Worker attempted to call the family. The Speech Language Pathologist (SLP) saw her on Sunday. I am unsure if the Physician was notified.<br><br>During an interview on 06/13/2025 at 09:08 AM, Medical Director stated, I can not confirm or deny my awareness R78 left against medical advice.<br><br>During an interview on 06/13/2025 at 9:09 AM, Certified Nursing Assistant (CNA)1 revealed that she was assigned to work with R78 on 03/23/2025. CNA1 stated, I assisted R78 with personal care around 1:00 PM and no later than 2:15 PM. R78 was dressed in a short sleeve green shirt, black leggings and some non-skid yellow socks, with no shoes or undergarments and her legs were covered, with a sheet. CNA1 further explained, I last saw R78 sitting inside the building at the front door around 2:30 PM or 2:40 PM. CNA1 stated that the resident had an issue with her right arm, but was able to use a wheelchair, she never walked but was able to stand and pivot to a chair. CNA1 further revealed that she left for the day around 2:55 PM or 3:00 PM and the resident was no longer at the door, she was unaware where the resident was and that she did not know that the resident had left the facility until she returned to work on Monday, 03/24/2025.<br><br>(continued on next page) |

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| | 425172 | A. Building<br>B. Wing | 06/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Magnolia Manor - Greenwood | 1415 Parkway Drive<br>Greenwood, SC 29646 |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 06/13/25 at approximately 01:15 PM, the Administrator revealed that upon admission to the facility, the resident was made aware of the facility's policy regarding leaving the facility and acknowledged understanding by signing the admission handbook. During the survey, the Administrator stated that R78 had a BIMS of 14, she was cognitive and she had told staff that she would be leaving to go to the store with family and that the resident had a right to leave. The Administrator acknowledged at the time of the incident and currently, the whereabouts of the resident remained unknown, the facility had not considered this an elopement, so they did not notify the local authorities and/or continue to look for R78.<br><br>Facility provided the following removal plan:<br><br>Resident 78 no longer resides at the facility.<br><br>The Social Worker attempted to call the resident & her son on 3/24/25. Voice message was left for both contacts and no call back were received.<br><br>Adult protective services were notified to do welfare check on 06/16/25.<br><br>Police department was notified to do wellness check on 06/16/25.<br><br>.<br><br>Elopement Risk evaluations done in the past 90 days on current residents inhouse will be reviewed by Director of Nursing/Designee for accuracy by 6/13/25. Residents identified at risk will be reviewed for appropriate interventions including placement in the Elopement Binder and validated care plans have interventions listed.<br><br>The Director of Nursing was reeducated by the Clinical Consultant on 6/13/25 on Accidents and Incidents and Resident Care including:<br><br>o Elopement risk<br><br>o validating that when a resident is leaving and or expressing the desire to leave the facility the nurse is aware and the resident and/or responsible party has signed the resident out for leave of absence<br><br>o elopement risk assessment process and putting interventions in place based on risks identified.<br><br>Validation with in service attendance sheet signature.<br><br>Facility Staff will be reeducated by 6/13/25 by the Director of Nursing/Designee on Accidents and Incidents including:<br><br>o elopement risk<br><br>o validating that when a resident is leaving the facility and or expressing the desire to leave the facility the nurse is aware and the resident and/or responsible party has signed the resident out for leave of absence<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Any staff not receiving this education by 6/13/25 will receive prior to working the next scheduled shift. This will be presented in New Hire Orientation.<br><br>Nursing Staff will be reeducated on 6/13/25 by the Director of Nursing/Designee on Accidents and Incidents and Resident Care Including:<br><br>o Elopement Risk<br><br>o Validating that when a resident is leaving the facility and or expressing the desire to leave the facility the nurse is aware and the resident and/or responsible party has signed the resident out for leave of absences<br><br>o Elopement risk assessment process accuracy<br><br>o Checking for residents needs approximately every 2 hours<br><br>o Notifications to Charge Nurse or Director of Nursing as indicated when a resident is not located<br><br>Any staff not receiving this education by 6/13/25 will receive prior to working the next scheduled shift. This will be presented in New Hire Orientation.<br><br>An elopement drill will be completed on 6/13/25 that includes:<br><br>o The Administrator will notify the Charge Nurse, Director of Nursing and Social Service Designee that a resident is missing. The Director of Nursing/designee will announce Code [NAME] to signal the Elopement Drill Procedure<br><br>o The Director of Nursing/designee will organize an immediate and thorough search of the center and surrounding grounds. The entire search process will be completed within 30 minutes<br><br>o If the search fails to locate the missing resident in the allotted time, the Administrator/designee will place a mock telephone call to the appropriate community agencies, resident's legal representative and attending physician.<br><br>Staff will provide the mock police with all the physical identifying information<br><br>o The Search will continue if resident not located to include 2 staff members searching the surrounding streets by care for a 2 mile radius<br><br>o When the volunteer resident is located the Charge Nurse will complete a head to toe assessment. The Social Services Designee will assess the resident for emotional distress. The Director of Nursing will notify the appropriate community agencies, attending physician and the resident's legal representative.<br><br>o The facility's Quality Assurance Committee will investigate the incident and implement interventions to prevent reoccurrences<br><br>o When the missing resident is found, an announcement will be made, Code [NAME] all clear.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The Director of Nursing will randomly interview a minimum of 2 staff daily to validate understanding of elopement risk and elopement binder for 5 days, then weekly for 3 weeks then monthly for 2 additional months.<br><br>The Director of Nursing/Designee will validate elopement risk assessments for accuracy beginning 6/13/25 in clinical morning meeting.<br><br>The Medical Director was notified on 6/13/25 of the Immediate Jeopardy.<br><br>A review of the facilities policy and procedures on leave of absence, resident's signing out, and Elopement was conducted on 6/13/25. No loopholes or changes were identified or needed during the review.<br><br>An Ad Hoc Quality Assurance and Performance Improvement Meeting was held on 6/13/25 to discuss contents of this plan.<br><br>Administrator will oversee compliance of this plan. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>Based on review of the facility policy, observations, record review and interviews, the facility failed to ensure a medication administration error rate of less than 5 percent. The medication administration error rate was 8 percent for 2 out of 25 opportunities observed for error.<br><br>Findings include:<br><br>Review of the facility's policy titled, Medication Management Program revised 05/05/2023, revealed, Policy: The facility implements a Medication Management program to meet the pharmaceutical needs of patients and residents, according to established standards of practice and regulatory requirements.<br><br>Security and Safety Guidelines:<br><br>16. Medications are dispensed at the time of administration. Pre-pouring or dispensing for a later administration is not permitted.<br><br>Administering the Medication Pass<br><br>7. The authorized staff member prepares one resident's medication at a time.<br><br>B. Do not touch the medication when opening a bottle or unit dose package<br><br>C. If a medication which is not in a protective container is dropped, it should be discarded according to policy.<br><br>15. If a medication is unavailable, contact pharmacy and document accordingly. Notify the physician for possible alternatives available in e-kits at time of discovery.<br><br>16. Once removed from the package or container, unused doses should be destroyed following facility policy and documenting the destruction according to facility policy.<br><br>During an observation on 06/11/2025 at 03:30 PM, Registered Nurse (RN)3 placed Reglan and Buspirone in her bare hands and placed in a medication cup.<br><br>During an interview on 06/11/2025 at 03:36 PM, RN3 stated, That is ridiculous. It is going to take too long placing the medication directly in the medicine cup. The medicine will end up on the medicine cart more than in the medicine cup. I washed my hands. No one else does it that way.<br><br>During an observation on 06/11/2025 at 03:45 PM, R22's medication was removed from the medication cart included Tylenol 500 mg [milligrams] by mouth (PO) and Tramadol 50 mg PO. Gabapentin 600 mg PO and hydroxyzine HCL 50 ml were not available. RN3 proceeded with medication pass.<br><br>During an interview on 06/11/2025 at 03:45 PM, RN3 stated, I don't see R22's Gabapentin or Hydroxyzine, I guess he doesn't have any in this cart.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation on 06/11/2025 at 03:55 PM, RN3 offered R26 his medication in the hallway. The resident was slumped slightly to the right in the wheelchair. The resident attempted to take the medications, but one pill dropped on the floor. RN3 picked it up and stated, One pill dropped on the floor. I guess I can get another one not unless you want to take this one. R26 responded, I can take that one. After intervention of the surveyor, RN3 responded, I'll go get you another one.<br><br>During an observation on 06/11/2025 at 04:03 PM, RN3 placed the dropped pill in the trash can on the medication cart. RN3 proceeded to prepare another pill for R26.<br><br>During an interview on 06/11/2025 at 04:03 PM, RN3 stated, I do not know what pill I dropped. I think I know what it is. I will compare it to Baclofen by what it looks like. This medication is not an opioid. Since it is an antibiotic, it should be ok to discard it in the trash can. No, I do not know what the policy says on discarding non opioid medications.<br><br>During an interview on 06/11/2025 at 04:19 PM, the Director of Nursing (DON) stated, RN3 works here often. She is agency staff. She knows our policies. I expect all medications to be given per our policies. She will be placed on the Do Not Return (DNR) list. The DON was also asked about medication availability. She stated, We have those medications to give. I expect all medications to be given as per our policies. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility policy, observations and interviews, the facility failed to ensure expired medication and biologicals, and 4 loose unidentified pills were removed from 2 of 2 medication carts. The facility further failed to remove open and expired items from 1 of 2 treatment carts.<br><br>Findings include:<br><br>Review of the facility's policy titled, 8.2 General Guidelines for Storage of Medication and Biologicals,<br><br>revised [DATE], revealed Policy: Medications and biologicals are stored safely, securely and properly following manufacturer's recommendations or those of the supplier. In accordance with State and Federal laws, the facility will store all drugs and biologicals in locked compartments under proper temperatures and other appropriate environmental controls to preserve their integrity.<br><br>Procedures:<br><br>5. Medications with manufacturer's expiration date expressed in month and year (e.g., May, 2019) will expire on the last day of the month. (unless a sooner expiration date has been placed on the package by the pharmacy).<br><br>6. Once any medication or biological package is opened, the facility should follow manufacturer/supplier guidelines with respect to expiration dates of opened medications.<br><br>12. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction, and reordered from the Pharmacy, if replacements are needed.<br><br>During an observation on [DATE] at 12:23 PM of [NAME] Medication Cart revealed; 2 loose yellow unidentified pills and 1 white unidentified pill, floor Stock Vitamin D3, 10 mcg [microgram] (400 IU) Plus Phar Lot# 63376 expired on 04/25, Iron 27 mg [milligram] Geri Care Lot# 724W03, Expired 04 2025, and 3 Bisacodyl 10 mg medicated Laxative Suppositories OTC [over-the-counter] Stock Lot# ZD006, Expired 04/2025.<br><br>During an interview on [DATE] at 12:49 PM, Registered Nurse (RN)1 stated, Floor Nurses and Manager usually check the cart. For the loose medications, we have a drug buster we place loose pills in. The suppositories and Vitamin D3 will be discarded in a big trash can in the Director of Nurses (DON's) office. The Vitamin D3 will go to the DON office for disposal.<br><br>During an observation on [DATE] at 12:49 PM, RN1 disposed of the medications in the black receptable bin in the DON's office.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation on [DATE] at 01:20 PM, Birch Medication Cart B revealed 1 loose yellow pill, Humalog Kwik Pen dated 05/04 expired 4/28 from the open date, and Albuterol Sulfate aerosol 90mcg, Lot# 1820164 expired on 12/2023.<br><br>During an interview on [DATE] at 01:24 PM, Licensed Practical Nurse (LPN)1 stated, The Assistant Director of Nursing (ADON) and LPN3 checks the carts. I am an agency staff member.<br><br>During an observation on [DATE] at 01:24 PM, LPN1 discarded the Aspirin in the drug buster. The insulin and inhaler medications were discarded in the medication needle box on the side of the medication cart.<br><br>During an observation on [DATE] at 04:52 PM, The [NAME] Park Treatment cart revealed the following: [NAME] Valve, non-sterile package, open Rf M9000 ICU Medical Lot 5584922 expired [DATE] and the Ready Prep PVP povidone iodine 10% solution Lot# 11kJAO40E, expired 10/24.<br><br>During an interview on [DATE] at 06:34 PM, the DON stated, RN2 uses the cart when she does wounds and making rounds. LPN3 checks the [NAME] wing. The nurses are responsible for checking the medication carts for expiration dates. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on review of the facility policy, observations, and interviews, the facility failed to ensure foods that were stored in the freezer, refrigerators and dry food storage were appropriately sealed, labeled, dated with a use by date, and/or discarded after the manufacturer's expiration date. This had the potential to affect all residents who received meal trays from the kitchen.<br><br>Findings include:<br><br>Review of the facility's policy titled, Food Safety in Receiving and Storage, with a revision date of 6/20/2023 revealed, Receiving Guidelines 6. Check expiration dates and use by dates to assure dates are within acceptable parameters; General Food Storage Guidelines 3.) .Label both the container and its lid with the common name of the contents, the date, it was transferred to the new container and the discard date; Dry Storage guidelines 2. Tightly seal open packages to prevent contamination or place food in covered container.<br><br>Review of the facility's policy titled, Dating and Labeling Food Guidelines, updated 2/4/2024, revealed .when opening food in dry storage, make sure food has a label with date opened/one month expiration date. Six months for condiments; All opened frozen foods returned to the freezer needs to be bagged/labeled.<br><br>During an observation on 06/10/25 at 10:24 AM, the kitchen's dry food storage revealed one 5-pound (lb.) bag of self-rising corn meal opened and not labeled with an open or use by date and one 16-ounce (oz.) box of lasagna noodles opened and not sealed properly or labeled with an open or use by date. The walk-in cooler revealed one 1-gallon (gal.) container of dill pickle chips marked open 3/15/25 out 5/15/25; one 16 oz. container of ham base marked open 2/27 and an ilegible out date. The walk-in freezer revealed one box containing 4 open bags of churros, not properly sealed and not labeled with an open or use by date.<br><br>During a follow-up observation on 06/12/25 at 1:56 PM, the walk-in freezer revealed one 1-gal. size Ziploc bag of meatballs, marked with an open date of 3/29/25 and use by date of 5/29/25.<br><br>During an interview on 06/12/25 at 2:31 PM, the Dietary Manager revealed that the food is handled by the kitchen and dietary staff to make sure there is nothing expired.<br><br>During an interview on 06/16/25 at 07:31 PM, the Administrator revealed that it is her expectations that foods that are expired are discarded. The Administrator also stated that any foods in the dry food storage, refrigerators or freezers that have been opened, should also be dated. The Administrator further revealed that sometimes things are mislabeled with dates that exceed the required date. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, and interviews, the facility failed to ensure the useof gowns during catheter and wound dressing changes 2 of 2 residents reviewed, Resident (R)35and R57.<br><br>Findings include:<br><br>Review of the facility's policy titled, Transmission Based/Standard Precautions, and Enhanced Barrier Precautions revised on 05/15/23 revealed, Policy: 1. The facility will use transmission-based precautions when the routes of transmission is not completely interrupted using standard precautions alone. These are applied as needed based on the epidemiology of the infecting organism or infectious disease syndrome. There may be some diseases that have multiple routes of transmission which more than one transmission-based precaution may be required. Transmission-based precautions will always be used in addition to standard precautions.<br><br>2. Health care workers (HCW) will implement Universal/Standard Precautions whenever there is occupational exposure to blood and body fluids.<br><br>Procedures:<br><br>Enhanced Barrier Precautions (EBP)<br><br>1. Enhanced Barrier Precautions expand the use of PPE (gowns and gloves) during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing.<br><br>A. EBP will be implemented for All residents with the following:<br><br>2) Wounds and/or indwelling medical devices (central lines, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO colonization status<br><br>B. EBP will be implemented during the following high-contact resident care activities:<br><br>7) Device care or use: central lines, urinary catheter, feeding tube, tracheostomy/ventilator<br><br>F. The facility will post clear signage on the door or wall outside of the room indicating the type of precautions and required PPE (gowns and gloves)<br><br>G. The facility will post signage that clearly indicates the high-contact resident care activities that require the use of gown and gloves.<br><br>H. The facility will provide gowns and gloves immediately outside of the resident's room and position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing car for another resident in the same room.<br><br>Standard Precautions vs. Transmission Based Precautions<br><br>4. Rationale for Transmission-Based Precautions<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 5. Signs<br><br>a) Confidentiality is to be maintained as much as possible while still following all applicable regulations. Health Insurance Portability and Accountability Act (HIPPA) regulations are applicable.<br><br>Review of R35's Face Sheet revealed R35 was admitted to the facility on [DATE] with diagnoses including but not limited to; pressure ulcer of sacral region and pressure ulcer of unspecified elbow,stage 4.<br><br>Review of R35's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/08/25 revealed R35 had a Brief Interview for Mental Status (BIMS) score of 09 out of 15, indicating moderate cognitive impairment.<br><br>Review of R35's Physician Orders dated 06/04/25, revealed the following order for woundtreatment: Location sacrum keep sacral open area clean and dry. Insert alginate wound dressinginto wound. Apply foam dressing to cover area. Change Monday (M)-Wednesday (W)-Friday (F).<br><br>Review of R57's Face Sheet revealed R57 was admitted to facility on 05/12/25 with diagnoses including but not limited to; unspecified injury of external genitals, subsequent encounter andother specified injuries of external genitals, subsequent encounter.<br><br>Review of R57's admission MDS with an ARD of 05/27/25 revealed R57 had a BIMS score of 03 outof 15, indicating severe cognitive impairment.<br><br>Review of R57's Physician Orders dated 04/23/25, revealed the following order, Urethral cathetercare every shift may be completed by certified nursing assistant (CNA) or nurse.<br><br>During an observation on 06/12/25 at 10:56 AM, observation of R57 ' s room showed no EBP signageon the door. CNA2 and CNA3 washed their hands and applied gloves. CNA2 and CNA3 did not use agown during catheter care for R57. CNA2 and CNA3 took off their gloves and sanitized their hands.<br><br>During an interview on 06/16/25 at 07:47 PM, CNA3 stated, R57 ' s EBP signs are not up on the door. Itreally depends on when we would put a gown on for resident care. We had a 1 on 1 in-service in January,and we have a skills fair coming up.<br><br>During an observation on 06/12/25 at 11:11 AM, observation of R35 ' s room did not have EBPsignage outside of room door. RN2 washed her hands and applied gloves. RN2 changed R35 ' ssacral dressing. RN2 removed her gloves and washed hands.<br><br>During an interview on 06/12/2025 at 11:30 AM, RN2 stated, I thought about the gown after theprocedure. I had it out and everything. I forgot to put it on.<br><br>During an interview on 06/12/25 at 11:36 AM, the Director of Nursing (DON) stated, The EBP signsare inside the closet doors with supplies. We do not put them on the doors to help withconfidentiality. This is a small town, and a lot of people know each other. So, the confidentialitywould not be confidential with the EBP signs on the door. |