STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425090	A. BUILDING _____ B. WING _____	**09/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAGNOLIA MANOR - GREENVILLE	**411 ANSEL ST GREENVILLE, SC 29601**

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 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to provide an environment free of potential abuse for two of six sampled residents (Resident #3 and Resident #4) reviewed for resident to resident altercations. Specifically, staff failed to provide adequate supervision for Resident #5 with known, intermittent, aggressive behaviors. Resident #5 was able to hit and/or kick Resident #3 and Resident #4 (on separate occasions) before staff could intervene and separate the residents. This failure had the potential to effect any resident residing in the facility due to Resident #5's ambulatory status and his/her known impulsive and aggressive behaviors. Findings include: 1. Review of a dhec (Department of Health and Environmental Control) ,[DATE]-Hour Report, dated [DATE], reported an incident in which Resident #5 approached Resident #3 in the East Hall dayroom and struck him/her in the chest. Resident #3 attempted to retaliate, and Resident #5 responded by attempting to choke Resident #3. Staff intervened and separated the residents and assessed each for injuries. No injuries were identified for either resident. The facility made the appropriate notifications and initiated an investigation. The local police department was notified and responded. No charges were filed. Review of Resident #3's face sheet in the electronic medical record (EMR) revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #3 was alert, ambulatory via wheelchair and continues to reside on the East wing of the facility. Resident #3's Brief Interview for Mental Status (BIMS) score indicated moderate cognitive impairment but the resident was able to make his/her needs known to staff. On [DATE] at 9:04 AM, Resident #3 was observed in the resident's room, up in his/her wheelchair and pleasantly confused. When asked the resident denied knowledge of any altercations with other residents and stated that he/she feels safe in the facility. 2. Review of a DHEC Reportable Incident document dated [DATE] revealed the ambulatory Resident #5 kicked Resident #4 as s/he walked past Resident #4 seated in his/her wheelchair. Staff intervened promptly and separated the residents. Both were assessed and no injuries were identified. Appropriate notifications were made and an investigation initiated. Review of Resident #4's face sheet revealed the resident was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of a Psychiatric Follow Up Note dated [DATE] for Resident #4 revealed the resident was alert but confused, .S/He is typically up in his/her wheelchair during the day .grabbing anyone who passes by him/her .on hospice services now . Resident #4 expired on [DATE] in the facility. Review of Resident #5's face sheet revealed a re-admission date of [DATE] following an acute care behavioral health assessment and admission. The resident was admitted to the facility with [DIAGNOSES REDACTED]. Resident #5 expired on [DATE]. Review of Resident #5's Psychotherapy Comprehensive Clinical assessment dated [DATE] revealed, .The patient has become aggressive and argumentative with other residents .no apparent triggers and lashes out indiscriminately toward others .behavior has been like this for over a month and increasingly difficult for staff to manage . The psychotherapy note further documented that the resident had functioned well prior to a recent and rapid decline and had been placed on hospice care. The face to face visit note documented .resident observed ambulating .dancing at times and talking nonsensically .upon approach severely confused. Review of Resident #5's quarterly Minimum Data Set (MDS) with an ARD of [DATE], indicated the resident's BIMS score was 99 indicating the resident was unable to complete the interview due to cognitive deficits. Review of the Electronic Medical Record (EMR) revealed a behavioral care plan for Resident #5 that included multiple interventions in response to Resident #5's impulsive behaviors. The interventions included a geri-psychiatric admission and continued psychiatric services in the facility, medication adjustments, room changes, and intermittent one to one supervision when he/she exhibited aggressive behaviors. During an interview on [DATE] at 10:10 AM, Licensed Practical Nurse (LPN) #1 said he/she was assigned to Resident #3's care that date . LPN #1 stated that Resident #3 had speech deficits following a stroke but that he/she could communicate with some words and body language to make his/her needs known. LPN #1 was an agency nurse but was working via contract with the facility. LPN #1 said he/she is working in facility full time and was familiar with the residents. LPN #1 was not aware of any resident to resident altercations involving Resident #3 and he/she was not familiar with Resident #4 or Resident #5, both of whom had expired in the facility a few weeks ago. During an interview with the Director of Nursing (DON) on [DATE] at 3:00 PM, the DON confirmed the events as reported. The DON confirmed Resident #5 was increasingly impulsive and aggressive towards other residents. (Resident name) was usually so sweet, but s/he could turn in a flash, and his/her behaviors were becoming more frequent. We (staff) try to stay on top of it but we just can't be between them all the time. The DON stated there were many occasions when Resident #5 had to be placed on one to one and/or line of sight supervision, but that even then, it was impossible to know when or why he/she may strike out. The DON stated, .we (facility)can't staff one to one for every resident that has behaviors. The DON confirmed Residents #3 and #4 were struck by Resident #5 as noted above and both residents had the right to live in a safe environment free from physical abuse from any source, including other residents. Review of the facility policy titled Abuse, Neglect, Exploitation, or Mistreatment revised [DATE] revealed, .POLICY: 1. The facility's Leadership prohibits neglect, mental, physical and/or verbal abuse .1. Abuse is the willful infliction of injury .2. Adverse event .is an untoward, undesirable, and usually unanticipated event that causes death or risk of serious injury .5. Ongoing assessment, care planning, and monitoring of patient/residents with .A. History of aggressive behaviors .F. Residents with a history of resident to resident altercations. The Facility Reported Incident #SC 582and #SC 639 were investigated during the COVID-19 and Complaint survey conducted [DATE]-[DATE] and resulted in this cited deficient practice at F600.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** Based on record review, observations, staff interviews, and policy review the facility failed to: 1. Ensure that all staff appropriately wore required personal protective equipment (PPE) in resident care areas. Additionally, the facility failed to provide and encourage residents to use facial coverings when out of their rooms. 2. Ensure staff perform proper hand hygiene practices during the provision of resident cares, and between resident contacts. These deficient practices had the potential to affect all 86 residents residing in the facility at the time of the survey; and potentially increased the risk of exposure to COVID-19 within the facility for all residents and staff. Findings include: 1. During a random observation on the West Hall, while conducting a facility tour on 09/10/20 at 9:50 AM, a Housekeeping/laundry staff (HS #1) was observed assisting a resident with his/her laundry. HS #1 was noted to lean over the resident seated in his/her wheelchair while in a conversation with the resident. HS #1's mask was pulled down below his/her chin exposing the staff's nose and mouth as s/he spoke to the resident. HS #1 face/mouth was within a few inches of the resident's face as he/she spoke. When asked, HS #1 was aware what PPE is required in resident care areas and HS #1 stated, .I knew better but s/he (resident) don't (sic) hear good .that's why . During an observation on 09/10/20 at 11:10 AM, at the West hall nurse's station two Licensed Practical Nurses (LPN #2 and LPN #3) were at the desk. Both LPNs stated they were agency nurses but had been

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) working at the facility regularly and were familiar with the residents. LPN #3 was wearing the required facemask improperly, exposing his/her nose. LPN #3 said the mask .fits OK, but it gets hot and I must've forgot to pull it back up . when asked by the surveyor. LPN #2 and LPN #3 were asked about the three residents that were ambulatory in the hallway and the four residents that were seated in the dayroom, near the nurse's station. None of the residents were wearing facial coverings of any kind. Social distancing was sporadic and not rigidly enforced by staff. Both LPN #2 and LPN #3 stated, .they thought the residents were supposed to wear masks but you can't make them .they won't keep it on . When asked where masks for residents were kept the LPNs said, I don't know I guess they use what we do. 2. During an observation on 9/11/20 at 9:40 AM, during the west wing medication pass, LPN #1 did not don gloves nor sanitize his/her hands between patient encounters. LPN #1 delivered medications to a resident in one room; returned to the medication cart, collected medications for a resident in the room next door, and delivered those medications without washing his/her hands. Hand hygiene should be performed when there is contact with a resident or the resident's environment, and between resident care encounters, as a standard of practice to reduce and prevent the spread of infections. When asked about his/her hand hygiene LPN #1 stated that s/he had become nervous and forgot to do it. In an interview with the DON at 11:00 AM on 09/11/20, the DON stated that s/he was made aware of the observation and of the LPNs failure to perform hand hygiene by LPN #1. The DON stated, .we (facility) have already conducted staff counseling and education with LPN#1 about hand hygiene. In an interview with the DON and the Administrator on 09/10/12 at 12:15 PM, the DON and Administrator confirmed .masks are to be worn at all times for all staff - no exception .as far as the residents go, that's another story. This is their home and we can't force them to wear it, especially if they are demented . Both confirmed the facility policy cited below was the procedure currently being implemented; and it states for residents to wear masks when outside their rooms. Review of the facility's undated policy/procedure titled COVID-19 1.) Preparation/Suspected/admitted stated, .if resident must leave room, must wear mask prior to leaving room . 2.) The policy also directed, .staff perform hand hygiene (even if gloves are worn) in the following situations: Before and after contact with the resident .after contact with objects and surfaces in the residents' room .before perform procedures .