STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115553	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAGNOLIA MANOR OF MIDWAY	652 NORTH COASTAL HIGHWAY 17 MIDWAY, GA 31320

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and review of the facility policy titled, Care Plans-Comprehensive Person-Centered the facility failed to follow the care plans for one of five residents (R) (R#33) and the facility failed to develop a care plan for dysphagia for one of five residents (R#44). Findings include: 1. Review of facility policy titled 'Care Plans-Comprehensive Person Centered' (not dated), revealed: 'The care plan will be reviewed and updated with the participation resident and resident representative(s) and all personnel involved in the care of the resident as needed and no less than quarterly. 3. The care plan is available for use by all personnel providing care/services to/for the resident. It includes but is not limited to: A. Incorporate identified problem areas; B. Incorporate risk factor(s) associated with identified problems; F. Prevent declines in functional status and/or functional levels. 5. Care plans are revised as changes in resident condition dictates. Reviews are made at least quarterly.' Record review revealed that R#33 was readmitted to the facility from a psychiatric hospital on [DATE] with [DIAGNOSES REDACTED]. Review of R#33 care plans revealed: Hypertension; give anti-hypertensive medications as ordered. [MEDICAL CONDITION] medications for behavior management; administer [MEDICAL CONDITION] medications as ordered by Physician. Review of the Physicians Orders for October 2019 for R#33 revealed an order for [REDACTED].#33 was administered his medication as ordered. 2. Review of the medical record for R#44 revealed he was admitted to the facility 8/26/2019 with the [DIAGNOSES REDACTED]. Quarterly Minimum Data Set ((MDS) dated [DATE] reveals a Brief Interview of Mental Status (BIMS) assessment score of zero out of 15, indicating severe cognitive impairment. Review of R #44 medical record revealed an order on admission from assisted living facility for nectar thick liquids. Review of care plan provided to facility from assisted living facility revealed resident had an issue with choking on certain foods. Review of care plans for R #44 revealed there was no evidence that the facility developed a care plan to address the resident's dysphagia. Interview with the Director of Nursing (DON) on 3/11/2020 at 12:23 p.m. revealed she expected medications to be given as ordered.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews the facility failed to follow physician's order for two of five residents (R#44, R#33) reviewed for following Physician Orders. Findings include: 1. Review of R #44 medical record revealed he was admitted to the facility 8/26/2019 with [DIAGNOSES REDACTED]. Annual Minimum Data Set (MDS) reveals a Brief Interview of Mental Status (BIMS) assessment score of zero out of 15, indicating severe cognitive impairment. Review of R #44 medical record revealed an order on admission from assisted living facility for nectar thick liquids. Physician's order form for R #44, with no date noted, revealed no order for nectar thick liquids. Review of care plan provided to the facility from the assisted living facility revealed R#44 had an issue of choking on certain foods. Review of nurse's notes dated 9/15/2019 at 2 p.m. for R #44 revealed resident spitting in plate, on his spoon, and putting it in food. Chewing up food and spitting it back onto his plate. Nurse's notes dated 9/16/2019 at 10:35 a.m. for R #44 revealed resident chewing up soft foods (grits and eggs) and spitting it back onto plate. Nurse's note date 9/18/2019 4:30 p.m. for R #44 revealed resident experiencing extensive drooling and when eating or trying to swallow medications that have been crushed and placed in pudding, he swallows the food/medication then immediately coughs it back up. Physician's telephone order dated 9/18/2019 at 5:00 p.m. revealed order for a Modified [MEDICATION NAME] Swallow Study (MBSS) with speech therapist present diagnosis (dx) of dysphagia. Nurse's notes dated 10/6/2019 8:49 p.m. for R #44 revealed resident continues to spit food back in plate at mealtimes. Review of a Physician's telephone order dated 10/07/2019 revealed an order for [REDACTED]. Chief complaint/History of present illness: cough. Nurse reports resident continues to cough. Review of NP note dated 10/07/2019 for R #44 revealed no MBSS due to copay per nurse report. Review of NP progress noted dated 10/10/2019 for R #44 revealed occasional loose NP (non-productive) cough per staff. Interview on 3/11/2020 at 9:43 a.m. with the Director of Nursing (DON) revealed the DON confirmed the order for nectar thick liquids was not written on admission and the order for nectar thickened liquids was not written until 10/07/2019. Interview on 3/11/2020 at 12:23 pm DON revealed when residents are admitted or readmitted to facility orders are reconciled by the nurses and checked the following day in morning meeting by the Intermediate Disciplinary Team (IDT). Interview on 3/11/2020 at 3:51 p.m. Licensed Practical Nurse (LPN) AA, (Admission Nurse) revealed she did not see the order for nectar thickened liquids with the paperwork for R#44 when he was admitted to the facility. LPN AA further revealed the physician orders from the assisted living facility in R #44 medical record are the orders she transcribed to the physician order for [REDACTED].> 2. Record review revealed that R#33 was readmitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. Review of the hospital discharge orders (not dated) for R#33 documented an order for [REDACTED]. Further review revealed that this medication was not signed as administered on 10/16/19 at 9:00 p.m., 10/18/19 at 9:00 a.m., 10/21/19 at 9:00 a.m. or 9:00 p.m., and was discontinued 10/23/19 at 9:00 p.m. and the word error was written on the order. 2. [MEDICATION NAME] 25 mg one tablet po (orally) q a.m. (every morning) was administered daily on 10/18/19 through 10/23/19 Interview with the Director of Nursing (DON) on 3/11/2020 at 12:23 p.m. revealed when residents are readmitted to the facility from a hospital the orders are reconciled by the nurse and checked the following day in the morning for accuracy. The DON stated she would expect the medications to be administered as ordered.
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and review of the facility policy titled Admission/Transfer/Discharge the facility failed to administer medications according to the Physicians order for one of five residents (R) (R#33) reviewed for medications. Findings include: Review of the policy titled Admission/Transfer/Discharge not dated revealed the facility complies with all State and Federal regulations. Resident (R) #33 was readmitted to the facility from a psychiatric hospital on [DATE] with [DIAGNOSES REDACTED]. Review of the hospital discharge orders (not dated) for R#33 indicated the following orders: New medications: [REDACTED]#33 revealed an order for [REDACTED]. [MEDICATION NAME] 25 mg tablet take half tablet (12.5 mg) po bid [MEDICAL CONDITION](hypertension) was not signed as administered on 10/16/19 at 9:00 p.m., 10/18/19 at 9:00 a.m., 10/21/19 at 9:00 a.m. or 9:00 p.m., and was discontinued 10/23/19 at 9:00 p.m. and the word error was written on the order. 2. [MEDICATION NAME] 25 mg One tablet po q a.m. (every morning) was administered on 10/18/19 through 10/23/19

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

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.

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F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Further record review of the MARs from January 2019 through October 2019 for R#33 revealed there was not any evidence that the following medications were administered as ordered: [MEDICATION NAME] 1000 units 1 tablet qd (daily) was not signed as administered on 1/17/19 and 10/18/19 [MEDICATION NAME] 10 mg tablet half tablet q hs (bedtime) was not signed as administered 1/15/19 [MEDICATION NAME] 5 mg tablet 1 tablet bid was not signed as administered on 10/15/19 at 9:00 p.m. and 10/18/19 at 9:00 a.m. [MEDICATION NAME] 300 mg tablet po (orally) 150 mg bid was not signed as administered on 10/15/19 at 9:00 p.m. and 10/18/19 at 9:00 a.m. Quetiapine 100mg tablet po 200 mg tid (three times daily) was not signed as administered on 1/15/19 at 2: p.m. and 9:00 p.m., 10/16/19 at 2:00 p.m., 2/18/19 at 9:00a.m. and 2:00 p.m., 10/24/19 at 2:00 p.m., 10/25/19 at 9:00 p. m., and 10/27/19 at 2:00 p.m. Ziprasidone 20 mg tablet po 60 mg bid (twice daily) was not signed as administered on 10/15/19 at 9:00 p.m., 1/18/19 at 9:00 a.m., and 10/19/19 at 9:00 p.m. [MEDICATION NAME] 500 mg tablet po bid (twice daily) was not signed out as administered on 10/15/19 at 9:00 p.m., 10/16/19 at 9:00 p.m., 10/20/19 at 9:00 p.m., 10/21/19 at 9:00 a.m. and 9:00 p.m., and 10/22/19-10/25/19 at 9:00 a.m. Interview with the Director of Nursing (DON) on 3/11/2020 at 12:23 p.m. revealed when residents are readmitted to the facility from a hospital stay the orders are reconciled by the nurse and checked the following day in the morning for accuracy. The DON stated she expected medications to be given as ordered. The DON further stated that she had seen problems and was working on an action plan to address the issues; however, no action plan was offered for review.