STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425032	A. BUILDING _____ B. WING _____	03/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAGNOLIA MANOR - INMAN	63 BLACKSTOCK ROAD INMAN, SC 29349

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 0554 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Allow residents to self-administer drugs if determined clinically appropriate.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interviews, the facility failed to assess the ability of a resident to self-administer oral medications that were left at the bedside for one (Resident #214) of four residents observed during medication administration. The findings included: Resident #214 had [DIAGNOSES REDACTED]. Review of the annual Minimum Data Set ((MDS) dated [DATE], revealed Resident #214 was cognitively intact. The MDS also specified the resident's hearing was adequate but his/her vision was severely impaired. Review of the clinical record did not reveal an assessment to determine Resident #214's ability to keep medications at the bedside or a physician's orders [REDACTED]. Nurse #8 was observed during medication administration for Resident #214 on 0[DATE] at 12:49 PM. When Nurse #8 took the medications to the resident and placed them on the over-bed table, there was already a medication cup on the over-bed table with the identical medications. The medications being administered and the medications already on his/her overbed table included: [MEDICATION NAME] 10 milligrams (mg), a medication to control blood pressure [MED] [MEDICATION NAME] 800mg, a medication for [MEDICAL CONDITION] Senna 2 tablets, a medication for constipation Aspirin 325mg, a medication for pain At 0[DATE] at 12:58 PM, while still at the bedside, Resident #214 and Nurse #8 were interviewed about the medications already on the overbed table. Nurse #8 said, Yes, I just saw those. They are the same medications I'm giving now so they must be from lunch yesterday or something. S/he stated they were not the resident's morning medications. Resident #214 appeared confused and said, I thought those were the medications I'm supposed to take now. Resident #214 could not explain why the medications were on her overbed table. Nurse #8 administered the medications s/he had prepared and removed the medications that were already on the overbed table when she entered the resident's room. The Director of Nursing Services (DON) was interviewed on 0[DATE] at 5:22 PM, about residents who had been assessed for self-administration of medications. The DON said, We don't have anyone for self-administration of medications. The DON was interviewed again on 03/13/2020 at 6:10 PM. The DON indicated s/he expected the nurses would see the medications swallowed and not left at the bedside.
F 0567 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Honor the resident's right to manage his or her financial affairs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, it was determined the facility failed to ensure residents had access to money in their personal funds accounts on the weekends. This failed practice affected two residents (Residents #46 and #147) out of three residents reviewed for personal fund accounts (PFA). The findings included: 1.a. Resident #46 was admitted to the facility on [DATE] and was assessed to have a Brief Interview for Mental Status (BI[CONDITION]) of 15 on the most recent quarterly Minimum Data Set (MDS), dated [DATE]. This BI[CONDITION] score indicated the resident was cognitively intact. S/he stated during the resident interview on 0[DATE]20 at 9:36 AM that he was not able to get money from his PFA on the weekends. 1.b. Resident #147 was admitted to the facility on [DATE] and was assessed to have a BI[CONDITION] of 14 on the most recent MDS, dated [DATE]. This BI[CONDITION] score indicated the resident was cognitively intact. S/he stated during the resident interview on 0[DATE]20 at 9:07 AM that s/he could only access money in his PFA Monday through Friday. An interview was conducted with the Regional Accounts Manager on 03/13/2020 at 4:53 PM. S/he stated there was a cash box available on the weekends and the residents could get money from there. S/he stated she would clarify which nurses' station the cash box was located. S/he stated she would also make sure these residents were aware of this. At 5:15 PM on 03/13/2020, the Administrator stated they just realized the cash box was not being prepared for the weekends. S/he stated the previous Business Office Manager had quit approximately three weeks ago and had not prepared the cash box. S/he stated he did not know how long this had not been available to the residents.
F 0582 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.** Based on interviews and record reviews, it was determined the facility failed to ensure estimated costs for continued services were disclosed on the Skilled Nursing Facility Advance Beneficiary Notices of Non-coverage (SNFABN) forms for two (Residents #5 and #59) of three residents. The findings included: The Assistant Administrator identified 23 residents who had been discharged from Medicare Part A Services in the past six months with benefit days remaining. On 0[DATE], SNFABN forms were reviewed for Residents #5 and #59. The space on the form reserved for the estimated cost of care the resident may have been required to pay for out of pocket was left blank on both forms. On 03/13/2020 at 11:15 AM, Social Services Staff #1, who filled out the SNFABN forms, was asked if estimated costs should have been included on the forms. S/he said, Yes. On 03/13/2020 at 1:00 PM, the Administrator was made aware the forms had not been completely filled out and acknowledged the concern.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, it was determined the facility failed to ensure a clean, comfortable, homelike environment for four (Rooms 103, 110, 327 and 328) of 32 rooms observed. The facility census was 163. The findings included: 1. On 0[DATE]20 at 7:50 AM, a small bedside table in room [ROOM NUMBER]A was observed missing a bottom drawer. On 03/13/2020 at 4:30 PM, the Administrator (ADM) and Associate Administrator (AADM) accompanied the surveyor on a tour of the facility and made return observations of environmental concerns observed earlier in the survey. On 03/13/2020 at 4:35 PM, the ADM confirmed the observation by stating, That dresser is missing a bottom drawer. 2. On 0[DATE]20 at 9:38 AM, observation was made of room [ROOM NUMBER]. Dirty privacy curtains were observed. On 03/13/2020 at 4:30 PM, the Administrator (ADM) and Associate Administrator (AADM) accompanied the surveyor on a tour of the facility and made return observations of environmental concerns observed earlier in the survey. On 03/13/2020 at 4:38 PM, in room [ROOM NUMBER], the ADM agreed the privacy curtain separating the resident's beds was dirty. On 03/13/2020 at 4:50 PM, in room [ROOM NUMBER], the ADM and AADM confirmed three of the five curtains in the room were dirty and needed to be cleaned. The curtains were observed to have multiple brown, grey, and red spots and stains. On 03/13/2020 at 4:58 PM, in room [ROOM NUMBER], the ADM and AADM both stated two of the room's privacy curtains were dirty. 3. On 0[DATE]20 at 9:38 AM, observation was made of room [ROOM NUMBER]B. The wall behind the bed was observed to be s[REDACTED]ed. 03/13/2020 at 4:38 PM, in room [ROOM NUMBER]B, the Administrator walked to the bed nearest the window and looked at the wall behind the headboard. S/he stated the wall behind the headboard had been scratched from the bed moving up and down against the wall.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.**

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

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F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of Pain Medication (Resident #18) and Pre-Admission Screening and Resident Review (PASRR) (Resident #106), for two of 38 residents. The findings included: 1. Resident #18 had [DIAGNOSES REDACTED]. Resident #18's December 2019 Monthly Physician order [REDACTED]. The Physician's Desk Reference specifies that [MEDICATION NAME] is a medication used to treat nerve pain in adults. Review of the December 2019 Medication Administration Record (MAR) indicated Resident #18 received the scheduled medication [MEDICATION NAME] 800mg, every day at 8:00 AM, 2:00 PM and 8:00 PM. The MDS dated [DATE], indicated Resident #18 was not on a scheduled pain medication of any kind from 12/09/2019 through [DATE]. During an interview on 03/13/2020 at 5:50 PM, MDS Coordinator #2 said, I think of pain medication more like the narcotics. I just don't think of [MEDICATION NAME] as a pain medication. MDS Coordinator #2 added that s/he probably had not looked it up to see the action of the [MEDICATION NAME] medication. During an interview on 03/13/2020 at 6:10 PM, the Director of Nursing Services indicated she expected the MDS Coordinator to review the MAR and code the MDS accurately. 2. Resident #106 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident's Annual Minimum Data Set ((MDS) dated [DATE] indicated the resident's cognition was severely impaired and was verbally abusive towards others at least 1 to 3 days in a week. The MDS did not code Resident #106 as being approved for PASRR Level II in section A1510 of the MDS. A review of the PASRR Level II determination notification dated 07/25/2018, revealed Resident #106 was approved for PASRR Level II with no expiration date. On 03/13/2020 at 3:00 PM, an interview was conducted with the MDS Nurse #1. S/he reported the Annual MDS for Resident #106 should have been accurately coded for PASRR Level II because the resident had been approved for PASRR Level II since his admission to the facility. MDS Nurse #1 further stated in the future s/he will make sure s/he accurately coded the MDS in the area of PASRR Level II after s/he reviews the notification of the PASRR Level II determination. An interview was conducted with the Administrator on 03/13/2020 at 4:11 PM. S/he reported the PASRR Level II should have been coded accurately on Resident #106's annual MDS. The Administrator added s/he was going to in-service the MDS nurse to code the MDS accurately by verifying with the Social worker whether the residents at the facility had been determined to have a PASRR Level II when they have [DIAGNOSES REDACTED].
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 observations, interviews and record reviews, it was determined the facility failed to develop a comprehensive care plan for contact precautions for one (Resident #29) of two residents reviewed for transmission-based precautions. The Administrator identified two residents on transmission-based precautions. The facility census was 163. The findings included: Resident #29 had [DIAGNOSES REDACTED]. diff., a bacterial infection that can cause diarrhea), not specified as recurrent. A Discharge Minimum Data Set (MDS), dated [DATE], indicated s/he was cognitively intact in skills for daily decision making. S/he had taken antibiotics six of the last seven days prior to the assessment. A facility Re-admission History and Physical, dated 03/04/2020, indicated the Resident was [MEDICAL CONDITION] positive and to continue [MEDICATION NAME] (an antibiotic) as ordered and hand hygiene and contact precautions. A care plan dated 03/06/2020, indicated Resident 29 at risk for dehydration from diarrhea as Resident has [MEDICAL CONDITION] and contained no record indicating the intervention of contact precautions. A nurse's note dated 03/09/2020 at 9:30 PM, indicated the resident continued to take an antibiotic for [DIAGNOSES REDACTED]. infection. On 0[DATE]20 at 11:00 AM, shelving on the door to the resident's room was observed containing Personal Protective Equipment (PPE) of gowns, gloves and masks. There was no sign on the door with instructions to see a nurse before entering, the reason for the PPE, or the type of precautions to observe. On 0[DATE]20 at 12:00 PM, Registered Nurse #1 was asked why the resident was on transmission-based precautions. The nurse answered this was her first day back to work in 10 days after having the flu. S/he stated, prior to being off work, the resident had been to the hospital and returned to the facility with a [DIAGNOSES REDACTED]. infection. S/he stated the facility had also been isolating residents with the flu. S/he stated she really did not know why the resident was being isolated. On 03/13/2020 at 1:21 PM, the Clinical Services Director was asked if the resident's care plan included contact precautions. S/he stated the resident had contracted [DIAGNOSES REDACTED]. during a recent hospital visit and had been started on an antibiotic. S/he stated, while the resident's care plan included interventions related to diarrhea from [DIAGNOSES REDACTED]. and the risk of dehydration, contact precautions had not been added to the care plan. S/he acknowledged the resident's care plan had not included interventions for contact precautions. A facility policy titled, Person Centered Care Plan Process, documented that the facility will develop and implement a comprehensive care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, it was determined the facility failed to ensure residents were assisted with ADLs (activities of daily living) for four (Residents #29, #66, #106 and #147) of 38 sampled residents reviewed for provision of ADLs. The Clinical Services Director (CSD) identified 108 residents that required assistance with ADLs. The findings included: 1.a. Resident #29 had [DIAGNOSES REDACTED]. A Discharge Minimum Data Set ((MDS) dated [DATE], indicated s/he was cognitively intact in skills for daily decision making. S/he required total assistance from staff members with bathing. During the last seven days, s/he had not transferred between surfaces, including her bed. A care plan dated 1[DATE]19 directed staff to assist with showers two times a week and for staff to assist with partial or bed bath as needed. A Point of Care History Record dated 12/12/2020 to 0[DATE], indicated the resident's most recent bath was a partial bath on 02/13/2020, one month ago. On 0[DATE]20 at 1:34 PM, Resident #29 was observed in her room lying in bed. The Resident stated s/he had not had a bath in five weeks because there was not enough staff. S/he stated there were only two Certified Nurse Assistants (CNAs) on the evening shift. S/he stated she wanted a shower, but staff had told her/him there was not enough staff to give her/him a shower. On 03/13/2020 at 2:15 PM, the CSD was asked to review bath records for Resident #29. The records indicated the last time the resident had been bathed was a partial bath on 02/13/2020, one month ago. The CSD acknowledged 02/13/2020 was the last recorded bath and that it had been a partial bath. On 03/13/2020 at 2:34 PM, the Director of Nursing Services (DON) said, I want to be honest with you and save a lot of time for everyone looking for things that don't exist. If Resident #29 said s/he did not get a bath, s/he is honest, and did not receive a bath. 1.b. Resident #66 had [DIAGNOSES REDACTED]. A 5-Day Minimum Data Set ((MDS) dated [DATE], indicated s/he was cognitively intact in skills for daily decision making. S/he required total assistance from two staff members with bathing and extensive assistance from two staff members with personal hygiene. During the last seven days, s/he had not transferred between surfaces, including her bed. A physician's orders [REDACTED]. A care plan dated 01/06/2020 directed staff to assist with showers two times a week and to assist with partial or bed baths as needed. Point of Care History Records, dated from 02/13/2020 to 0[DATE], indicated s/he received only five complete bed baths over that time period. On 0[DATE]20 at 9:55 AM, Resident #66 was observed lying in bed. The Resident's hair was observed to be combed but slightly greasy. The Resident stated s/he only had her/his hair washed about once every two weeks and that s/he would like to have it washed at least once a week and had purchased an inflatable sink to make washing hair easier for the nursing staff. S/he stated the facility was short-staffed and s/he really hated to impose on them by asking to have her/his hair washed, because s/he knew bed baths took longer to do. The Resident stated she was menstruating and would really like a shower. The Resident stated she would like to be bathed often enough that she did not have to smell herself. On 03/13/2020 at 2:34 PM, the Director of Nursing Services (DON) was asked when residents should expect to have their hair washed. She stated usually hair was washed during showers or baths. S/he was informed Resident #66 did not get her hair washed during baths and would like to have her hair washed at least weekly. The DON stated s/he was not surprised. 1.c. Resident #108 had [DIAGNOSES REDACTED]. A quarterly Minimum Data Set ((MDS) dated [DATE], indicated the Resident was cognitively intact in skills for daily decision making. S/he required total assistance from one staff member with bathing. During the last seven days, s/he had not

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On 03/13/2020 at 3:44 PM, the Director of Nursing Services (DON) was shown bath records for Resident #108. The last complete bath documented for the resident was on [DATE]20. Partial baths had been documented on 03/02/2020, 03/06/2020, [DATE]20 and 03/11/2020. After reviewing the bath record, she was asked if staffing issues were the reason this resident was given partial baths instead of complete baths. S/he said, Yes, it was either due to short-staffing or the staff were not doing their jobs. On 0[DATE] at 11:32 AM, Certified Nurse Assistant (CNA) #1 stated there were not enough staff scheduled for the second shift from 3 PM to 11 PM. When asked if there were enough staff members to ensure residents received showers, s/he said, I have to be honest, No. S/he stated CNAs often had to rush through the provision of ADLs (activities of daily living) including showers. S/he stated she could recall times residents did not receive showers or baths because there were not enough staff to provide them. On 0[DATE] at 11:40 AM, CNA #2 stated some days staffing was short. S/he stated this negatively impacted the care residents received as staff were overworked, had to rush through tasks and were stressed. On 0[DATE] at 11:49 AM, CNA #3 stated s/he usually worked the day shift from 7 AM to 3 PM, and sometimes showers scheduled for the day shift were not given until the night shift because there was not enough staff on the first and second shifts. S/he stated some days were really bad when asked to describe staffing. On 03/13/2020 at 8:10 AM, CNA #4 said, lately staffing has been really bad. S/he stated the facility was occasionally short-staffed and it was hard to give the residents their scheduled baths and showers. S/he said staff often had to rush through showers and baths, and staff did not get to do a thorough job. She stated at times residents missed getting their showers and baths because there were not enough staff. On 03/13/2020 at 8:23 AM, CNA #6 stated most of the time the second shift on her/his unit only had two CNAs, and that was not enough to provide showers or baths to residents. S/he stated two weekends ago, s/he had arrived at work on a Saturday to learn residents on her/his unit had not received baths on the prior Thursday or Friday because there were not enough staff. On 03/13/2020 at 8:46 AM, the Resident Council President stated the facility was short-staffed. S/he stated because of short staffing, s/he usually receives one of her two scheduled showers each week. On 03/13/2020 at 2:34 PM and 3/14/2020 at 7:40 AM, the DON stated the facility had a lot of trouble completing scheduled baths. S/he stated she came in on the weekends and stayed over on weekdays to give baths. S/he said, They have staffing issues and don't have enough staff and have a problem keeping agency nurses and having enough staff to give baths. The DON confirmed s/he was in the building, on a Saturday giving residents' showers and baths because there was a shortage of staff. On 03/14/2020 at 11:30 AM, the Administrator, Assistant Administrator, CSD and DON acknowledged staffing was an area the facility had struggled with. The Administrator stated short staffing was The Core area they had determined was the most important for them to improve. A facility policy titled, Activities of Daily Living, Optimal Function, said the Facility will provide necessary care to all residents that are unable to carry out activities of daily living independently to ensure they maintain proper grooming and hygiene. 2. Resident #147 was admitted to the facility on [DATE] with [MEDICAL CONDITION], end stage [MEDICAL CONDITION], and limitation of activities due to disability. The Quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated the resident had a Brief Interview for Mental Status (BI[CONDITION]) of 14 out of 15, indicating the resident was cognitively intact. S/he required maximum assistance of one person to complete his bathing. Resident #147's Plan of Care (POC) dated 02/21/2020 indicated s/he was at high risk for self-care deficit related to the required assistance needed to perform ADLs, including nail care. On 0[DATE]20 at 9:09 AM, Resident #147 was observed to have long fingernails. A few were jagged at the edges. Resident #147 stated the staff had to be reminded to cut them. On 03/11/2020 at 2:35 PM, Resident #147 was observed to have very long fingernails. A few were jagged at the edges. Resident stated that s/he would like to get them cut. On 03/13/2020 at 2:58 PM, Resident #147 was interviewed. The Resident stated that s/he had asked Certified Nursing Assistant (CNA) #11 to cut her/his nails that morning. CNA #11 told the resident s/he would be back, but did not return prior to leaving for the day. On 03/13/2020 at 3:17 PM, Licensed Practical Nurse (LPN) #10 was interviewed. LPN #10 stated the expectation for nail trimming should be done during the resident's shower. LPN #10 and this surveyor met with Resident #147. LPN #10 stated s/he observed the resident's long nails as soon as s/he walked into the room. S/he indicated that she had not observed her/his long nails previously. LPN #10 stated Resident #147 enjoyed her/his showers but could not speak to why her/his nails had not been trimmed.
F 0678 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure resuscitation code status documented in the medical record was in accordance with the resident's wishes. This affected two (Residents #153 and #163) of three sampled residents. The medical records indicated the two residents were Full Code, but based on interviews, it was their wish to be a Do Not Resuscitate (DNR). The findings Included: 1. Resident #153 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment, dated 02/21/2020, indicated Resident #153 had a Brief Interview for Mental Status (BI[CONDITION]) of 14 out of 15 indicating very minimal cognitive impairment. Resident #153 was deemed to have medical decisional capacity by her/his physician, the Medical Director. The resident's medical record indicated a status of Full Code. A physician's note, dated 11/19/2019, indicated Resident #153 was a Full Code but s/he wished to be a DNR. On 03/11/2020 at 10:49 AM, Resident #153 was interviewed. Resident #153 stated that no one at the facility had asked about her/his code status preference except her/his doctor. The Resident stated s/he had told her/him that s/he did not want to be resuscitated. On 03/11/2020 at 5:51 PM, the Medical Director was interviewed via telephone. The Medical Director stated s/he wrote orders for the Resident's code status. S/he stated that code status should be documented on a written order, in the history and physical (H&P) and a form under the Advanced Directive tab in the medical record. The Medical Director stated I should have written a DNR order for Resident #153 when she told me she wanted to be a DNR. On 03/11/2020 at 7:05 PM, NP #2 and this surveyor interviewed Resident #153. The resident stated s/he needed to think about if she wanted to be a Full Code or DNR. On 0[DATE] at 8:30 AM, Resident #153 stated to NP #2 her/his desire was to be a DNR. 2. Resident #163 was admitted to the facility on [DATE] for antibiotic therapy related to a Stage 4 pressure ulcer and [MEDICAL CONDITION]. The admission Minimum Data Set (MDS) assessment, dated [DATE]20, indicated the resident had no memory impairment. Resident #163 was deemed to have medical decisional capacity by his physician, the Medical Director. The resident #163's medical record indicated a status of Full Code. On 03/11/2020 at 7:05 PM, Nurse Practitioner (NP) #2 and this surveyor interviewed Resident #163. Resident #163 stated that he wanted to be a DNR from the day he was admitted , and he had shared that with the staff. On 03/11/2020 at 12:35 PM, the Admissions Director (AD) was interviewed. The AD stated upon admission, all residents are provided with information regarding Advanced Directives, Living Wills and Code Status. The AD stated, even if they make choices prior to being admitted to the facility, all residents enter as a Full Code until they are seen by the doctor and it is determined if they had the capacity to make medical decisions. On 03/11/2020 at 12:26 PM, the Social Services Director (SSD) was interviewed. The SSD stated s/he would meet with a new resident and/or their power of attorney (POA) or responsible party within 24-72 hours after admission to the facility. At that time, s/he would discuss the code status of a resident to confirm their wishes. If not already completed, s/he would notify the Medical Director to write an order for [REDACTED]. I think this all needs to be done within 24-48 hours.I'm not really sure of the policy. On 03/11/2020 at 4:26 PM, the Social Services Assistant (SS #1) was interviewed. SS #1 stated the Nurse Practitioners (NP) ask residents and/or their responsible party about code status upon admission and the Medical Director confirms the NP findings on decisional capacity on Tuesdays. On 03/11/2020 at 5:51 PM, the Medical Director was interviewed via telephone. The Medical Director stated s/he wrote her/his own orders for code status and that code status should be documented on a written order, in his history and physical (H&P) and a form under the Advanced Directive tab in the medical record. On 03/11/2020 at 5:39 PM, the Clinical Services Director (CSD) was interviewed. The CSD stated that if a resident had decisional capacity upon admission, their wishes should have been followed and a physician's orders

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F 0678 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) [REDACTED]. There should have been a physician's orders [REDACTED]. S/he stated the process was not followed.
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 interview and record review, the facility failed to ensure that a physician's order was obtained for a change in [MEDICATION NAME] dosage (an [MEDICAL CONDITION] medication) for one (Resident #104) of 48 residents reviewed for physician orders. The findings included: Resident #104 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The most current Minimum Data Set, dated dated [DATE], coded this resident with a Brief Interview for Mental Status of 15 out of 15, which indicated the resident was cognitively intact. A medical record review revealed an order signed by the Nurse Practitioner (NP #2), dated [DATE]20, 1) [MEDICATION NAME] 75mg (milligrams) one po (by mouth) q (every) day x 14 days. 2) Contact isolation related to positive for flu. A nurse's note on 03/05/2020 indicated new orders were received for [MEDICATION NAME] to D/C (discontinue) [MEDICATION NAME] 75 mg po BID (twice a day) x 5 day. New order [MEDICATION NAME] 30 mg po BID x 3 days. The order for the [MEDICATION NAME] 75mg was discontinued on the Medication Administration Record [REDACTED]. An interview was conducted with the Director of Nursing Services and the Clinical Services Director on 03/14/2020 at 10:20 AM. Both stated they were unable to locate any additional physician's order or notes related to the change in the [MEDICATION NAME] dosage.
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** Based on interviews and record reviews, the facility failed to ensure there were sufficient nursing staff available 24 hours per day to meet the residents' needs. The facility census was 163. The findings included: During the initial resident interviews beginning on 0[DATE]20, the following concerns were expressed by alert and oriented residents: On 0[DATE]20 at 9:08 AM, Resident #147 stated at night it can take over an hour to get their call light answered. On 0[DATE]20 at 9:33 AM, Resident #46 stated on the 100 hallway, the night shift often works with only one Certified Nursing Assistant (CNA) for 30 people. On 0[DATE]20 at 10:40 AM, Resident #97 stated they were losing the good staff because they were overworked. Sometimes there was only one CNA there on the night shift. On 0[DATE]20 at 11:52 AM, Resident #55 stated there was not enough staff to provide incontinent care and to provide them with beverages. On 0[DATE]20 at 12:56 PM, Resident #39 stated it could take up to an hour for the staff to answer a call light, if they came at all. On 0[DATE]20 at 1:17 PM, Resident #49 stated when they needed their pain medications, the call light was not always answered. On 0[DATE]20 at 2:20 PM, Resident #163 stated it was hard to get help during the evening and night shifts because they were often short staffed. On 0[DATE]20 at 3:13 PM, Resident #11 stated there was not always enough staff to clean them up in a timely manner after being incontinent. On 0[DATE]20 at 4:38 PM, Resident #124 stated that s/he was asked to move to a different unit because s/he wasn't getting her pain medications in a timely manner. On 0[DATE] at 11:32 AM, CNA #1 stated there were not enough staff scheduled for the second shift from 3 PM to 11 PM. When asked if there were enough staff members to ensure residents received showers, s/he said, I have to be honest, no. S/he stated CNAs often had to rush through the provision of ADLs (activities of daily living) including showers. S/he could recall times residents did not receive a shower or bath because there was not enough staff to provide them. On 0[DATE] at 11:40 AM, CNA #2 stated some days staffing was short. S/he stated this negatively impacted the care residents received as staff are overworked, rush through tasks, and are stressed. On 0[DATE] at 11:49 AM, CNA #3 stated she usually worked the day shift from 6 AM to 3 PM, and sometimes showers scheduled for the day shift were not given until the night shift because there was not enough staff on the first and second shifts. S/he stated some days were really bad, when asked to describe staffing. On 03/13/2020 at 8:10 AM, CNA #4 said, lately, sometimes, staffing has been really bad. S/he stated the facility was sometimes short-staffed and it was hard to give the residents their scheduled baths and showers. S/he said staff often had to rush through showers and baths, and staff did not get to do a thorough job. She stated at times residents missed getting their showers and baths because there was not enough staff. On 03/13/2020 at 8:23 AM, CNA #6 stated most of the time on the second shift her unit only had two CNAs, and that was not enough staff to provide showers or baths to residents. S/he stated two weekends ago, s/he had arrived at work on a Saturday to learn residents on her unit had not received baths on the prior Thursday or Friday because there was not enough staff. Additionally, when asked if residents' meals were served warm, CNA #6 stated it was difficult to serve the evening meal timely because the facility was short-staffed. S/he stated, because of the delay in service, the food was sometimes cold. S/he added, sometimes the food comes from the kitchen cold. On 03/13/2020 at 8:46 AM, the Resident Council President stated the facility was short-staffed. S/he stated because of short staffing, s/he usually only received one of her two scheduled showers each week. On 03/11/2020 at 1:00 PM, the Director of Nursing (DON) stated approximately 65% of the nursing staff came from an agency. The facility was trying to hire their own staff but had to use agency. Much of the agency staff were being used for the vacant positions on the 3 PM - 11 PM shift and the 11 PM - 7 AM shift. On 03/14/2020 at 10:54 AM, the Nursing Home Administrator (ADM) and Assistant Nursing Home Administrator (AADM) were interviewed. They stated in a 24-hour period, there should be 42 CNAs to be fully staffed. They had days where they only had 36 CNAs in a 24-hour period. On 03/13/2020, staffing schedules were requested from the facility. The facility was unable to provide accurate staffing schedules for the previous two weeks. The schedules did not include what the census was in the facility or who worked. On 03/14/2020, the facility provided staffing schedules for 0[DATE]20, [DATE]20, 02/29/2020 and 03/01/2020. Attached to the staffing schedules were payroll records. Upon detailed review, this surveyor was unable to match the payroll records with the provided schedule, therefore the facility was unable to show evidence of enough staff. On 03/14/2020 at approximately 11:20 AM, the AADM stated whatever payroll records s/he was able to find were attached to the schedule. S/he stated, we gave you what we had (payroll records). On 03/13/2020 at 2:34 PM and 3/14/2020 at 7:40 AM, the DON stated the facility, had a lot of trouble getting baths done. S/he stated she came in on the weekends and stayed over on weekdays to give baths. S/he said, We have staffing issues and don't have enough staff and wee have a problem keeping agency nurses and having enough staff to give baths. The DON confirmed s/he was in the building, on a Saturday, giving residents showers and baths because there was a shortage of staff. On 03/14/2020 at 11:30 AM, the ADM, AADM, CSD and DON acknowledged staffing was an area the facility had struggled with. The Administrator stated short staffing was The Core area they had determined was the most important for them to improve.
F 0730 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Observe each nurse aide's job performance and give regular training.** Based on interviews and record review, the facility failed to complete an annual performance review for five of five facility employed Certified Nursing Assistants (CNAs). The findings included: Five randomly selected CNAs that had been employed at the facility for more than a year were selected for review. On 03/13/2020 at 5:02 PM, the Human Resources Director (HR) was interviewed. The surveyor requested to review the annual performance reviews of the five randomly selected CNAs that had been employed at the facility for more than a year. The HR Director stated the facility was not currently doing annual performance reviews. On 03/13/2020 at 5:10 PM, the Clinical Services Director (CSD) confirmed the facility was not doing annual performance reviews.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, manufacturer's instructions, and staff interviews, the facility failed to label medications with a shortened expiration date in two of five medication carts reviewed (Cart A/Unit 2 and Cart A/Unit 4). The findings included: 1. A review of the manufacturer's storage instructions for [MED] [MED] pens specified that once opened, the [MED] pens must be used within 28 days or be discarded, even if they still contain [MED]. Accompanied by Nurse #2, the contents

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	425032	A. BUILDING _____ B. WING _____	03/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAGNOLIA MANOR - INMAN	63 BLACKSTOCK ROAD INMAN, SC 29349

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) of the Unit 4, Medication Cart A was conducted on 03/13/2020 at 7:49 AM. The cart contained an undated [MED] [MED] pen for Resident #55. Nurse #2 did not know who opened it or when it was opened. Examination by the nurse revealed that it still contained some [MED]. Unit Manager #1 removed the undated [MED] pen from the cart and replaced it with one that was unopened from the refrigerator. 2. A review of the manufacturer's storage instructions for [MEDICATION NAME] pens indicated it should not be used after the expiration date stamped on the label or 28 days after it was first opened. Accompanied by Nurse #1, the contents of the Unit 2, Medication Cart A were inspected on 03/13/2020 at 4:59 PM. The cart contained a [MEDICATION NAME] pen for Resident #50 that was undated. Nurse #1 indicated s/he had not noticed it earlier in the day. Nurse #1 said, It should have been dated. It was probably opened when I was off for two weeks. Examination by the nurse revealed some of the [MED] had been used. Nurse #1 removed the pen from the Medication Cart. An interview was conducted with the Director of Nursing Services (DON) on 03/13/2020 at 6:10 PM regarding both undated [MED] pens. During the interview the DON indicated her expectation was that all [MED] pens should be dated when removed from the refrigerator and/or opened.
F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide seven of 14 sampled residents with food meeting their taste preferences, which included complaints of palatability and appetizing temperatures. (Residents #147, #66, #128, #83, #39, #29, and #163) The findings included: Resident #66's cognition was coded as intact in the Admission MDS dated [DATE]. On 0[DATE]20 at 9:53 AM, an interview with Resident #66 indicated the food was terrible. Resident #128's cognition was coded as intact in the quarterly MDS dated [DATE]. On 0[DATE] at 10:07 AM, an interview with Resident #128 indicated the food tasted bad. Resident #83's cognition was coded as intact in the quarterly MDS dated [DATE]. On 0[DATE]20 at 10:08 AM, an interview with Resident #83 indicated the food tasted bad. Resident #29's cognition was coded as intact in the Annual MDS dated [DATE]. On 0[DATE]20 at 2:02 PM, an interview with Resident #29 indicated the food tasted terrible. Resident #163's cognition was coded as intact in the Admission MDS dated [DATE]. On 0[DATE]20 at 2:14 PM, an interview with Resident #163 indicated the food was awful. Resident #147's cognition was coded as intact in the quarterly Minimum Data Set ((MDS) dated [DATE]. On 0[DATE]20 at 9:11 AM, an interview with Resident #147 indicated most food at the facility was served cold. Resident #39's cognition was coded as intact in the quarterly MDS dated [DATE]. On 0[DATE]20 at 1:02 PM, an interview with Resident #39 indicated the food was not hot when served. On 03/13/2020 at 8:19 AM, when asked if residents' meals were served warm, Nurse Assistant (CNA) #5 stated sometimes breakfast was served late and cold. The Resident stated at times s/he had to warm up food for the residents due to late meals. On 03/13/2020 at 8:23 AM, when asked if residents' meals were served warm, CNA #6 stated it was difficult to serve the evening meal timely because the facility was short-staffed. S/he stated, because of the delay in service, food was sometimes cold. S/he added, sometimes the food comes from the kitchen cold. On 03/13/2020 at 12:25 PM, when asked if residents' meals were served warm, CNA #7 stated, when food was served on Styrofoam plates, it was often cold. During the interview on 0[DATE] at 2:30 PM, the Dietary Manager reported the cold food concerns had been expressed before at the Residents' Council Meeting. S/he encouraged staff in the units to immediately assist in passing out trays to residents, to prevent the food from getting cold. The Dietary Manager reported it took longer at times for the staff to pass the trays to the residents. During the interview on 03/13/2020 at 3:00 PM, the Administrator reported s/he had been encouraging staff to assist in passing meal trays to residents. S/he reported it seemed the staff were not consistent in passing the meal trays timely. S/he added the food should never be served cold to the residents. The Administrator stated s/he was going to in-service all staff to pay attention to meal carts and pass trays as soon as they were brought to the units.
F 0865 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have a plan that describes the process for conducting QAPI and QAA activities.** Based on record review and interviews, it was determined the facility failed to develop, implement and maintain documentation of a facility Quality Assurance and Performance Improvement (QAPI) Program. The facility census was 163. The findings included: On 03/14/2020 at 11:15 AM, four members of the facility's Quality Assessment and Assurance (QAA) committee met with the surveyor to discuss the QAPI program; The Administrator (ADM), the Assistant Administrator (AADM), the Clinical Services Director (CSD), and the Director of Nursing Services (DON). On 03/14/2020 at 11:18 AM, the ADM stated that when the previous ADM left the facility's employment, s/he had taken all the Performance Improvement Projects (PIPS) documentation, and s/he did not have documentation available related to QAPI efforts. Her/His first day of employment at the facility was 02/06/20. When asked about concerns surveyors had identified during the survey, the committee acknowledged they also identified areas of concerns; however, they stated they did not have documentation. On 03/14/2020 at 11:30 AM, the ADM, AADM, CSD and DON acknowledged staffing was an area the facility struggled with. The ADM stated short staffing was the area they had determined was the most important for them to improve; however, complete documentation of implementation of a QAA/PIPS program addressing this area could not be provided. A facility policy titled, Quality Assurance and Performance Improvement (QAPI) Program, documented: The QAA committee reports activities including implementation of the Quality Assurance and Performance Improvement program and that the QAPI program will gather data, analyze in various methods, track and trend patterns, implement process improvement and action plans to improve care and resident/patient services.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to maintain an effective Infection Control program to protect the residents, by putting them at risk for cross contamination. The facility failed to maintain infection control practices during medication pass for one (Resident #36) of four residents reviewed for medication pass. The facility failed to have a clear separation of the dirty and clean areas of the laundry room for one of one laundry rooms. (The facility census was 163.) The facility failed to ensure a resident's catheter bag was maintained under sanitary conditions when it was observed multiple times lying on the floor for one (Resident #163) of nine residents. The facility failed to don personal protective equipment (PPE) before entering the room of a resident on Contact Precautions for one (Resident #29) of two residents on Contact Precautions. The findings included: 1. On 0[DATE]20 at 4:20 PM, an observation was made of Licensed Practical Nurse (LPN) #6 checking the blood sugar of Resident #36 using a glucometer. The blood sugar level was 460 requiring coverage of [MED] ([MED] injection). LPN #6 went obtained the [MED] [MEDICATION NAME] (a pre-filled [MED] pen with a needle) and placed the [MEDICATION NAME] into the right pocket of her uniform shirt while s/he cleaned her/his hands using hand sanitizer. After s/he administered the medication, s/he again placed the [MEDICATION NAME] into the right pocket of her/his uniform shirt while s/he washed her hands in the resident's bathroom. LPN #6 took the [MEDICATION NAME] back to the medication cart and placed it into the top drawer with other residents' [MEDICATION NAME] without cleaning it. LPN #6 was asked why s/he had not cleaned the [MEDICATION NAME] before putting it back into the drawer since she had placed it into her/his pocket twice. LPN #6 stated that s/he had never heard of needing to clean the [MEDICATION NAME]. On 0[DATE] at 2:28 PM, an interview with the Director of Nursing (DON) was conducted. The DON stated s/he had heard about the observation and the nurse should not have put the [MEDICATION NAME] into her/his pocket. S/he further stated since the LPN did put it into her pocket, the expectation was that s/he should have cleaned the [MEDICATION NAME] before returning it to the cart. 2. Observation of the laundry room at the facility occurred on 03/13/2020 at 3:50 PM with the Housekeeping Supervisor (HS). The room measurements were approximately 20 feet x 20 feet per the HS. There were several hanging racks full of clean clothes (uncovered) approximately one foot from one a washing machine. There was no clear separation of the dirty and clean laundry areas. The HS stated that all linen/towels were sent to a vendor for laundering. The residents' personal clothing was laundered in the facility's laundry. The HS stated, It is pretty tight in here. An interview was conducted with the Administrator (ADM), the Director of Nursing (DON) and the Assistant Administrator (AADM) on 03/13/2020 at 4:25 PM. The ADM stated that s/he had been informed about the concern regarding the lack of separation from the dirty and clean laundry areas, but that s/he had seen smaller laundry rooms. The Infection Control policies provided by the facility were reviewed but the policies did not address this issue. 3. Resident #29 had [DIAGNOSES REDACTED]. diff., a bacterial infection), not specified as recurrent. A Discharge Minimum Data Set (MDS) assessment, dated 03/02/2020, indicated s/he was cognitively intact in skills for daily decision making. S/he had taken antibiotics six of the last seven days prior to the assessment. A facility Re-admission History and Physical, dated 03/04/2020, stated the Resident was [DIAGNOSES REDACTED] positive and to continue [MEDICATION NAME] (an

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) antibiotic) as ordered, Hand hygiene, and contact precautions. A care plan dated, 03/06/2020, indicated the Resident was at risk for dehydration from diarrhea since the Resident has [DIAGNOSES REDACTED]. On 0[DATE]20 at 1:10 PM, prior to entering Resident #29's room, this surveyor The door was observed to have no sign indicating the Centers for Disease Control category of transmission-based precautions (e.g. contact, droplet, or airborne), instructions for use of PPE, and/or instructions to see the nurse before entering. On [DATE]20 at 1:17 PM, an unknown Certified Nurse Assistant (CNA)was observed entering the room not wearing required PPE. S/he did not wash or sanitize hands when entering the room. S/he retrieved the resident's Styrofoam cup from the bedside table and said s/he was there to give the resident water. S/he left the room with the cup, without washing or sanitizing her/his hands. At 1:18 PM, s/he re-entered the room. Once again, s/he entered the room without donning a gown or gloves and did not wash or sanitize hands. S/he replaced the cup on the resident's bedside table and left the room without washing or sanitizing her/his hands. On 0[DATE]20 at 1:35 PM, the surveyor prepared to leave the room after interviewing the resident. Upon removing the gown, it was realized there was no trash can to dispose of the used gown or gloves. On 0[DATE]20 at 1:47 PM, Registered Nurse (RN) #1 (the charge nurse) was asked if a trash can should have been available to dispose of used PPE. S/he stated there should have been one by the door. S/he looked and confirmed there was not one and stated s/he would get one right away. S/he was informed that a CNA had entered and left the room twice without donning PPE or washing or sanitizing hands. S/he stated that was unacceptable and the CNA should have put on the PPE upon entering the room and washed her/his hands upon exiting. On 0[DATE] at 10:03 AM, the resident was asked if staff donned gowns and gloves when entering her/his room. S/he said, Sometimes they do, and sometimes they don't. On 03/13/2020 at 1:21 PM, the Clinical Services Director was asked what type of precautions should have been implemented for the resident. S/he stated the resident was on Contact Precautions, and staff should have been donning gowns and gloves before entering the resident's room. S/he stated hands should have been washed or sanitized upon leaving the room. 4. Resident #163 was admitted to the facility on [DATE] for antibiotic therapy related to a Stage 4 pressure ulcer and [MEDICAL CONDITION]. Resident #163 was incontinent of urine and had a suprapubic catheter (a tube inserted below the navel and into the bladder to drain urine). The Admission Minimum Data Set ((MDS) dated [DATE] indicated the resident had no memory impairment. Resident #163 was supervised with transfers from bed to wheelchair. A Plan of Care (POC) dated 03/11/2020 identified Resident #163 as high risk for a urinary tract infection [MEDICAL CONDITION] due to the suprapubic catheter. During the initial visit with Resident #163 on 0[DATE] at 12:14 PM, it was observed the resident's catheter bag was lying on the floor next to the bed. On 03/11/2020 at 10:00 AM, Resident #163's catheter bag was lying on the floor next to the bed. On 03/13/2020 at 9:26 AM, Resident #163's catheter bag was lying on the floor next to the bed. When interviewed, s/he stated it was her/his preference to leave it on the floor because it was easier for him to empty. On 03/13/2020 at 10:03 AM, Registered Nurse (RN) #3 was interviewed. She stated Resident #163 never shared her/his preference to keep the bag on the floor, but s/he would need to educate him that it was an infection control issue. RN #3 stated it was up to all employees, nurses, certified nursing assistants and housekeepers to monitor if a catheter bag was lying on the floor. On 03/14/2020 at 8:20 AM, Resident #163's catheter bag was again noted lying on the floor next to the bed.
F 0947 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.** Based on interviews and record reviews, the facility failed to ensure Certified Nursing Assistants (CNAs) received no less than 12 hours of required annual in-service training, including resident abuse prevention and dementia management training. This affected two (CNAs #9 and #12) of five facility employed CNAs and three (CNAs #14, #15 and #16) of three agency CNAs. The findings included: The training for five facility employed CNAs were requested for review. CNA #9 had only received six hours of the required 12 hours of annual in-service training. CNA #9 did not have the required annual resident abuse prevention training. CNA #12 was employed on an as needed basis. Human Resources was able to confirm CNA #12 had recently worked at the facility. The facility was unable to provide evidence that CNA #12 had received any in-service training within the last year, including the required annual resident abuse prevention training. Three agency CNA employee files were reviewed (CNA #14, #15 and #16). The facility was unable to provide evidence of the CNAs being oriented to the facility prior to start of their first shift. Additionally, the facility was unable to provide evidence of the required 12 hours of annual in-service training, including resident abuse prevention and dementia management training. On 03/13/2020 at 4:45 PM, the Director of Nursing (DON) was interviewed. The DON stated that it was her/his understanding that all agency staff go through a facility orientation prior to working. However, she was unable to locate evidence of the orientation and the agency for the CNAs was unable to provide proof of the 12 hours of annual in-service training, including resident abuse prevention and dementia management training.