STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425091	A. Building B. Wing	10/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Manor - Spartanburg	375 Serpentine Drive Spartanburg, SC 29303

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** 43313 Based on review of the facility's policy, record reviews, observations, and interviews, the facility neglected to provide wound care for 1 of 3 Residents (R)1, R2, and R3 per physician orders. Findings include: Review of the facility's policy titled, Abuse, Neglect, Exploitation, or Mistreatment, last revised 11/1/2017 documents: The facility's leadership prohibits neglect, mental, physical and/or verbal abuse, use of a physical and/or chemical restraint not required to treat a medical condition, involuntary seclusion, corporal punishment and misappropriation of a patient's/resident's property and/or funds and ensures that alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, and are reported immediately. R1 was admitted to the facility on [DATE] with diagnoses including, but not limited to: type 2 diabetes, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting the left non-dominate side. Review of R1's Physician orders dated 8/30/22 revealed an order to apply xeroform and cover with abd pad and tape, change daily. Review of the Treatment Administration Record (TAR) revealed wound care for R1 on 9/10/22 - 9/11/22 was documented as refused by R1, when it was not. Review of R1's progress notes revealed: 09/10/2022 02:29 PM Resident asked to receive treatments after dinner. This nurse will administer treatments at PM and document. 09/10/2022 06:06 PM This nurse went into residents' room at PM to do treatments and this resident refused 2x stating he was tired. During an interview on 10/3/22 at 1:35 PM, R1 revealed he never refused to have wound care provided to him. R1 revealed he did not receive wound care on 09/10/22 and 9/11/22 and said he would not refuse wound care because he did not want a hole in his buttocks. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/3/22 at 1:50 PM, the former Administrator reported Licensed Practical Nurse (LPN)3 came to him to discuss wound care. He [former Administrator] was told that R1 did not refuse wound care on 9/10/22 - 9/11/22 as documented in his progress notes. The former Administrator was also informed R1 had complained to staff that he was not provided wound care over the weekend. The former Administrator stated LPN1 and LPN2 initially reported that wound care was provided to R1 and after they were interviewed several times both LPN1 and LPN2 admitted that wound care was not provided to R1. During a telephone interview on 10/3/22 at 1:56 PM, LPN1 reported she did not want to talk about the wound care case without her lawyer present. At that time, the call was ended. During an interview on 10/3/22 at 1:59 PM, a telephone call was attempted to LPN2 without success. A second attempt was made on 10/3/22 at 2:43 PM message was left on her voice mail with call back information. During an interview on 10/3/22 at 2:06 PM, the Social Service Director (SSD) revealed R1 reported to the SSD that he did not get wound care over the weekend. The police were called and spoke with a lot of the residents. R1 reported that no wound care was performed on Saturday 9/10/22 and Sunday 9/11/22. Friday 9/10/22 was the last time wound care was provided for R1 and wound care should have been done daily if the orders are current. The SSD revealed she notified the Director of Nursing (DON) and former Administrator that R1 did not receive wound care but did not get a follow up on the outcome of the investigation. SSD revealed, to her knowledge, the facility investigation revealed the allegation of wound care not being done was substantiated and the LPN1 and LPN2 were immediately suspended. She reported R1's progress notes documented he refused wound care but R1 revealed he did not refuse wound care on 9/10/22 and on 9/11/22. SSD further revealed after the facility investigation, LNP1 and LPN2 were terminated. During an interview on 10/3/22 at 4:45 PM the wound care physician revealed R1 had physician orders for zero form dressing to be changed daily. The wound care physician revealed, LPN3 reported to her on 9/12/22 that the last time R1's wounds dressing was changed was on 9/9/22. The wound physician replied [R1] was quick to report he had not been given wound care over the weekend. She stated the wounds [R1] had deteriorated so a new order was placed for calcium alginate three times a week. During an interview on 10/4/22 at 12:19 PM the former DON revealed wound care was not charted as being done for two residents in the facility. The former DON stated LPN1 and LPN2 were both responsible for providing wound care to the residents. LPN1 and LPN2 admitted during the initial facility investigation that wound care was not provided and LPN1 and LPN2 were suspended the day after they were interviewed. The former DON revealed LPN1 and LPN2 turned in their resignations but their resignations were not accepted because the facility has a policy that states resignations would not be accepted while staff are on suspension. At the completion of the investigation, LPN1 and LPN2 were terminated. The former DON asked if the other wound care case would be investigated. The former DON was asked what she was referring to and she replied, this was not the only wound care case that the facility has and reported another staff was currently out due to not providing wound care. R2 was admitted to the facility on [DATE] with diagnosis including, but not limited to: unspecified injury at unspecified level of cervical spinal cord, type 2 diabetes mellitus without complications, quadriplegia, ankylosing hyperostosis, spinal stenosis, disease of spinal card, essential hypertension, cognitive communication deficit, other lack of coordination, and muscle weakness. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R2's physician order dated 08/24/22 revealed unstagable sacrum wound apply xeroform and abd pain adn tape daily. Further review of the TAR revealed on 09/10/22 - 09/11/22 that wound care was documented as done, when is was not. During an interview on 10/03/22 at 4:30 PM R2 revealed she has never refused wound care. During an interview on 10/3/22 at 4:45 PM the wound care physician revealed that R2 had an order for zero form dressing to be changed daily. LPN3 reported to her on 09/12/22 that the last time R2's dressing was changed was on 09/09/22. The wound care physician replied R2 was quick to report she had not been given wound care over the weekend. She revealed R2's wound had deteriorated, so a new order was placed for calcium alginate three times a week. During an interview on 10/04/22 at 9:45 AM, the DON reported this was her sixth day on the job, she was not here when this incident occured but she is aware of the incident. During the investigation staff kept reporting that wound care was done, then finally admitted wound care was not performed. The DON revealed to her knowledge this was the first time something like this had occurred at the facility. The DON was asked about her expectation from staff when documenting care, she responded, when you provide care sign off on the MAR/TAR only when care has been provided. During an interview on 10/04/22 at 10:30 AM. R2's family member revealed he was called by the facility and told R2's wound care was overlooked for a few days. He reported R2's wound did get worse and the facility reported they would be doing an investigation. R2's family member further revealed he has not been told the results of the facilities investigation. R2's family member concluded the interview with, I can see how wound care can be overlooked for a few days. I was happy that the facility stepped up to the plate to inform him that [R2's] wound care had not been provided because a lot of facilities will sweep this under the rug. R3 was admitted to the facility on [DATE] with diagnosis including, but not limited to: type 2 diabetes mellitus with diabetic chronic kidney disease, hypertension, adjustment disorder, hyperkalemia, unspecified atrial fibrillation, lymphedema, and idiopathic gout. R3's physician orders dated 08/30/22 revealed a diagnosis of a stage 2 pressure ulcer to right buttock and to apply collagen powder and dry dressing once daily. During an interview on 10/04/22 at 12:19 PM the former DON asked if we would be investigating the other wound care issue at the facility. The former DON revealed about a week after the wound care issues with R1 and R2, another issue with wound care for found. The former DON further revealed the wound care nurse LPN3 accused LPN4 of not proving wound care to R3. During an interview on 10/04/22 at 12:32 PM, LPN4 revealed she was currently on suspension. She was suspended last Thursday on 09/28/22 because another nurse LPN3 accused her of documenting wound care when she had not. LPN4 further revealed she had provided wound care to R3 and documented the care but LPN3 reported to the DON that LPN4 did not provide R3 with wound care. LPN4 revealed LPN3 presented a glove with a crumpled up old wound dressing and reported the dressing had an old date as proof wound care was not provided and she was suspended. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/04/22 at 1:05 PM, LPN3 revealed that LPN4 had not provided R3 with wound care on 09/26/22. R3's dressing on the day of 09/27/22 was dated 09/25/22. LPN3 further revealed she did not take a photo of the old dressing and reported her findings to the DON. She stated she was suspended on 09/27/22 for cussing out LPN4. During an interview on 10/04/22 at 1:25 PM, R3 revealed he has missed out on getting his wound care several times and the last time he was provided with wound care was the prior weekend. During an interview on 10/04/22 at 2:00 PM, LPN5 revealed she was told by LPN4 to go and remove all the dressings for all residents on Unit 2. LPN5 stated, she knew better and did not do this. LPN5 further revealed after rounds with the physician, LPN4 walked up to her and stated; I thought you were going to remove them all. LPN4 then walked away. LPN5 reported LPN3 and LPN4 had never gotten along and it was difficult working when they were both on duty.