| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 115124 | A. Building<br>B. Wing | 11/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Magnolia Manor of Columbus Nursing Center - East | 2010 Warm Springs Rd<br>Columbus, GA 31904 |

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 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, the facility failed to maintain a clean and comfortable environment for one of 97 resident rooms (room [ROOM NUMBER]). Specifically, the self-contained wall-mounted air conditioning unit (PTAC) displayed heavy substance buildup on the filter and had the potential to affect patient comfort and safety. Findings included:An observation of room [ROOM NUMBER] on 9/30/2025 at 11:30 am revealed that the PTAC unit filter was covered with a gray, flaky substance.An observation of room [ROOM NUMBER] on 10/1/2025 at 1:45 pm revealed that the PTAC unit filter was covered with a gray, flaky substance.An observation of room [ROOM NUMBER] on 10/2/2025 at 12:25 pm revealed the PTAC unit filter was covered with a gray, flaky substance.An interview on 10/2/2023 at 12:50 pm with the Interim Maintenance Director (IMD) confirmed the PTAC unit had a gray flaky substance on the pull-out filters. The IMD stated that the filter cleaning task should have been completed on 9/30/2025 and that all PTAC models should be maintained in a clean condition. |

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.

| 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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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>Based on observation, staff interviews, and review of facility policy titled Infection Prevention and Control, the facility failed to ensure that infection control hand hygiene practices were followed by three of three Licensed Practical Nurses (LPN) (LPN BB, LPN CC, and LPN AA) observed during medication administration. The deficient practice had the potential to contribute to the transmission of infectious diseases among residents and staff. Findings included:A review of the policy titled Infection Prevention and Control, last revised February 2021, revealed that it is the intent of the facility to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. It was further documented that the facility requires staff to wash their hands after each direct resident contact. During an observation on 10/2/2025 at 8:25 am, Licensed Practical Nurse (LPN) BB prepared and administered medication on the North 2 Low cart. LPN BB did not perform hand hygiene before setting up the medications or upon exiting the resident room. LPN BB then pushed the medication cart outside another resident's room and began to set up medications without performing hand hygiene.During an observation and interview with LPN CC on 10/2/2025 at 9:00 am, LPN CC prepared and administered medication on the North 2 High cart. LPN CC did not perform hand hygiene before setting up medications. LPN CC then proceeded into the resident's room and administered the medications. Subsequent interview with LPN CC confirmed she did not sanitize her hands before setting up medications and between residents. LPN CC acknowledged she should have sanitized her hands prior to setting up and administering medications. During an observation on 10/2/2025 at 9:24 am, LPN AA did not perform hand hygiene before setting up medications. LPN AA then entered the resident's room with medications, including two different eyedrops, completed hand hygiene, applied gloves, and administered an eyedrop into each eye. LPN AA then removed her gloves and gave oral medication without sanitizing her hands. During an interview on 10/2/2025 at 12:01 pm, LPN AA stated that she did not sanitize her hands before setting up medications. She stated she received infection control education upon hire and acknowledged that it is important to sanitize your hands when entering and exiting a resident's room and between medication passes to prevent the spread of infection.During an interview on 10/2/2025 at 12:08 pm, LPN BB revealed that she did not sanitize her hands during medication pass. LPN BB stated, I should have sanitized my hands between each resident. I was just nervous. LPN BB stated she attended infection control training and confirmed that not sanitizing her hands can transmit infections between residents. During an interview on 10/2/2025 at 12:35 pm, the Director of Nursing (DON) revealed that her expectation during medication pass is that staff use appropriate hand hygiene. She confirmed that everyone is trained on infection control upon hire. |