STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115553	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 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, record review, and facility policy review, the facility failed to prevent abuse for three of 26 sampled residents (R) (R1, R23, and R8).Findings included:1.Review of R1's Face Sheet located under the Resident tab of the electronic medical record (EMR), revealed R1 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis, major depressive disorder, dementia, and anxiety disorder.Review of R1's Care Plan located under the RAI [Resident Assessment Instrument] tab of the EMR, dated 02/28/23, contained the following Problem area, [R1] has been making false accusations to any and all staff that are caring for him. The care plan's goal specified, [R1] will not make accusations against staff by next review. The care plan's approach for staff included, Family informed of behaviors.Behavioral health group to follow [R1] for his psychological care. Staff educated to only give care in pairs to be witness to his accusations. Staff to investigate his accusations when necessary. Staff to ensure he is given adequate care.Review of R1's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/22/25, located in the RAI tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of seven out of 15 which indicated severe cognitive impairment. Review of R1's Progress Notes located under the Resident tab of the EMR for 10/10/25 through 10/24/25 revealed no notes regarding the alleged incidents.2. Review of R23's Face Sheet located under the Resident tab of the EMR, revealed R23 was admitted to the facility on [DATE] with diagnoses which included schizophrenia, Alzheimer's disease, dementia, and cognitive communication deficit.Review of R23's Care plan, located under the RAI tab of the EMR, dated 07/12/23, contained the following Problem area, Resident has alteration in thought processrelated to diagnosis of dementia as seen by short/long term memory, impaired decisionmaking skill, difficulty expressing and understanding information. The care plan's goal specified, [R23] will be out of room for socialization as desired over the next review period. The care plan's approach for staff included, Assist resident to activities to socialize as shedesires/allows.Review of R23's quarterly MDS with an ARD of 08/22/25, located in the RAI tab of the EMR, revealed a BIMS score of three out of 15 which indicated severe cognitive impairment. Review of R23's Progress Notes located under the Resident tab of the EMR for 11/26/25 revealed no notes regarding the observed incidents.3. Review of R8's Face Sheet located under the Resident tab of the EMR, revealed R8 was admitted to the facility on [DATE] with diagnoses which included parkinsonism, schizoaffective disorder, bipolar disorder, anxiety disorder, history of traumatic brain injury, altered mental status, and schizophreniform disorder. R8 was discharged from the facility on 11/26/25.Review of R8's quarterly MDS with an ARD of 08/20/25, located in the RAI tab of the EMR, revealed a BIMS score of 15 out of 15 which indicated he was cognitively intact and had not exhibited any physical, verbal, or other behavioral symptoms towards others.Review of R8's Care plan located under the RAI tab of the EMR, dated 09/16/25, contained the following Problem area, Resident has verbal behavioral symptoms directed toward others (continued on next page)

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: 115553	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER Magnolia Manor of Midway		STREET ADDRESS, CITY, STATE, ZIP CODE 652 North Coastal Highway 17 Midway, GA 31320	

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(impulsive, whispers in residents' ears, unwanted interactions). The care plan's goal specified, Resident will not threaten other residents, visitors, and/or staff. The care plan's approach for staff included, Allow distance in seating other residents around resident. Assess whether the behavior endangers the resident and/or others. Intervene if necessary. Avoid power struggles with resident. Maintain a calm environment and approach to the resident. Maintain a calm, slow, understandable approach. Praise resident when behavior is appropriate. Remove resident from group activities when behavior is unacceptable.Review of R8's Progress Notes located under the Resident tab of the EMR, revealed the following entries:-On 10/18/25 at 5:17 PM, Licensed Practical Nurse (LPN) 5 wrote Two CNAs [Certified Nursing Assistants] told writer about a conversation they overheard between this resident (R8) and his roommate [R1]. Both CNAs wrote a statement. The first CNA statement as follows: Roommate [R1] saying roommate [R8] takes his wheelchair and hits the bed. Walked in on him [R8] saying he will slap the roommate [R1]. Also says the roommate [R8] threatens him [R1]. [R8]: told roommate [R1] he [R8] will kill the whole family. Also said roommate [R1] and roommate [R1's] family will die from [.]. [R8] Told roommate he was going to steal roommates [R1's] belongings. Other CNA's statement: Mr (roommate) [R1] and Mr [R8] was [sic] threaten [sic] each on how they was [sic] going to killed each other family. Mr (roommate) [R8] said he was going to spread all Mr (roommate's) [R1's] [.] blood all his family. So they can die like him. The negative talking and threatening lasts for about 10 minutes. Unit manager [UM] was informed immediately and UM notified DON [Director of Nursing]. Unit manager also notified the state representative as this resident is a ward of the state. Writer informed [physician] at 1521 of room change. All of resident's items were transferred from that room to new room in [.].-On 10/19/25 at 11:32 AM, the DON wrote Spoke with resident [R8] regarding events of yesterday. He stated that he might have done it. He began rabbling about other residents and stated he hates it here and wants to leave because everyone is against him. When asked the specifics of the incident he said that the roommate [R1] is a nasty person with his infected self but would not clarify. When asked about his intent to harm self or others, he stated that he could if he (roommate) [R1] keeps on pushing me. I also questioned him about kicking another residents [unknown] chair, he admitted to the act but with no provocation. Resident will remain separated from other resident. Contacted his legal guardian.Requested placement at [inpatient behavioral health].-On 10/20/25 at 1:23 PM, Resident [R8] left for [inpatient psych facility] via stretcher with two EMS [emergency medical services] techs @1:10pm. No s/s [signs/ symptoms] of distress or discomfort noted at that time.-On 11/26/25 at 9:27 AM, Resident [R8] observed by [LPN1] hitting a female resident [R23] on her right elbow. Resident became aggressive with writer as he is being separated. He denied hitting anyone when I asked him. New order received to give Haldol 5mg [milligram] IM [intramuscular] Now per [physician] and obtain a bed for resident at inpatient psych facility. Resident is informed that [physician] wants him seen by inpatient behavioral services. Resident is now refusing ADL [activities of daily living] care.-On 11/26/25 at 5:24 PM, LPN1 wrote Resident [R8] transfer out [inpatient psych facility] via medical transport at 1730 for aggressive behavior and medication management.Review of the facility's investigation of the 10/18/25 incident between R1 and R8, provided by the facility, revealed the facility substantiated resident to resident abuse. Included in the facility's investigation was a witness statement from the staff who witnessed the incident. A witness statement written by CNA1, who was still employed at the facility at the time of the survey, indicated, 10/18/25 1:30pm [R1] and [R8] was [sic] threaten [sic] each other on how they was [sic] going to killed each other family. [unknown] said he was going to spread all [R1]'s.blood all his family. So they can die like him.Review of the facility's investigation of the 11/26/25 incident between R23 and R8, provided by the (continued on next page)

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Magnolia Manor of Midway	652 North Coastal Highway 17 Midway, GA 31320

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility, revealed the facility substantiated resident to resident abuse. Included in the facility's investigation was a witness statement from the staff who witnessed the incident. A witness statement written by LPN1, who was still employed at the facility at the time of the survey, indicated, 11/26/25 1600pm [4:00 PM] Resident [R8] was in 300 B hallway passing by another resident [R23] waiting to use the restroom when he [R8] swung his left arm hitting second resident [R23] in right arm. This nurse witnessed the incident and intervened before altercation could escalate. Resident denied hitting the second resident even when told it was visually seen. Resident was escorted to his room and incident was reported to unit manager.During an interview on 12/03/25 at 3:02 PM, CNA1 stated [R8] and [R1] didn't know she was sitting behind curtain. She stated [R8] came into the room in his wheelchair. She stated [R8] bumped his wheelchair into [R1]'s bed. CNA1 stated [R8] told [R1] that he had killed one of [R1's] family. She stated, then [R8] told [R1] that he was going to slit [R1]'s throat and spread his disease through his family. She stated she then moved [R8] out of room and notified her supervisor [LPN5]. She stated [R8] was then moved to another room. She stated it sounded like they were just talking to each other. She stated there was no yelling or raised voices.During an interview on 12/03/25 at 3:23 PM, R1 stated Roommate [R8] bumped my bed with his wheelchair. I told him to stop. He told me he killed my parents.During an interview on 12/03/25 at 4:10 PM, when asked about incident between R8 and R1, License Practical Nurse Unit Manager (LPNUM) stated I wasn't involved, I was off. When I came in, I found out the same day. Was told [R8] was over him, threatening him. Prior to being notified, the nurse was writing a statement. Nurse had CNA stay in room. [R8] was supervised until he was moved.I consider this an altercation between residents. [R1] is incapable of moving and defending himself. This was verbal abuse. I was told [R8] said he going to cut [R1]. [R8] was going to smear his blood over on his [R1]'s family member so they could all die from [his blood].During an interview on 12/03/25 at 3:34 PM, when asked about the incident between R8 and R1, the DON stated I was not present, it happened over weekend. They shared a room. [R8] threatened [R1] to do harm to him. Residents were separated until [R8] could be placed in behavioral health for the threats to harm to self or others. [R8] kept bumping [R1]'s bed with his chair.I substantiated the verbal abuse.During an interview on 12/04/25 at 3:33 PM, when asked about the incident between R8 and R1, LPN5, who was no longer employed by the facility, stated, I was told. I don't remember who told me.Someone told me [R8] said something about roommate having [diagnosis]. And that there was talk about [R8] doing something with his blood.I told supervisor and kept [R8] out of room.During an interview on 12/04/25 at 3:47 PM, when asked about the incident between R8 and R23, LPN1 stated I observed [R8] going down 300 hall and [R23] was waiting for the restroom when he swung his arm and hit her arm. It was a backhanded slap intentionally. She attempted to hit him back but missed. Before further escalation, I was able to remove him from the area. They were both in their wheelchairs. They had been arguing throughout the morning. She said [R8] was giving her the middle finger. This was not witnessed. I asked him to go away from her. We took him to his room, talked with him. He denied hitting her.He was sent to psych facility. I believe he went out the next day. After he got Haldol injection, he slept the rest of the day. He did not have a 1 on 1. We just rounded on him regularly every 2 hours.Review of the facility's policy titled, Abuse Prohibition / Reporting and Investigation, updated January 2017, indicated It is the intent of [Name] facilities to actively preserve each resident's right to be free from mistreatment, neglect, abuse or misappropriation of resident property. We believe that each resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment and involuntary seclusion. The purpose of these identified procedural guidelines is to create a standard of intolerance and to prevent the occurrence of any form of mistreatment, (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Magnolia Manor of Midway		STREET ADDRESS, CITY, STATE, ZIP CODE 652 North Coastal Highway 17 Midway, GA 31320	

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	neglect, abuse, or misappropriation of any resident and/or their property.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and facility policy review, the facility failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime and reporting of all alleged abuse violations to the State Agency (SA) for three of 26 sampled residents (R) (R1, R23, and R8). Findings included:1. Review of R1's Face Sheet located under the Resident tab of the electronic medical record (EMR), revealed R1 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis, Major depressive disorder, dementia, and anxiety disorder.Review of R1's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/22/25, located in the RAI tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of seven out of 15 which indicated severe cognitive impairment. 2. Review of R23's Face Sheet located under the Resident tab of the EMR, revealed R23 was admitted to the facility on [DATE] with diagnoses which included schizophrenia, Alzheimer's disease, dementia, and cognitive communication deficit.Review of R23's quarterly MDS with an ARD of 08/22/25, located in the RAI tab of the EMR, revealed a BIMS score of three out of 15 which indicated severe cognitive impairment. 3. Review of R8's Face Sheet located under the Resident tab of the EMR, revealed R8 was admitted to the facility on [DATE] with diagnoses which included parkinsonism, schizoaffective disorder, bipolar disorder, anxiety disorder, history of traumatic brain injury, altered mental status, and schizophreniform disorder. R8 was discharged from the facility on 11/26/25.Review of R8's quarterly MDS with an ARD of 08/20/25, located in the RAI tab of the EMR, revealed a BIMS score of 15 out of 15 which indicated he was cognitively intact and had not exhibited any physical, verbal, or other behavioral symptoms towards others.Review of the intake form received from the SA and the facility's provided documentation of electronic submission to the SA regarding an allegation of witnessed verbal abuse between R1 and R8 on 10/18/25 at 3:21 PM, revealed the SA received the report of the allegation of verbal abuse on 10/19/25 at 4:04 PM.Review of the facility provided undated investigative documentation, revealed a staff member witnessed verbal threats that R8 threatened to slap R1 and kill him and his family on 10/18/25 at 3:21 PM. During an interview on 12/03/25 at 3:02 PM, Certified Nursing Assistant (CNA) 1 stated she reported the incident immediately to Licensed Practical Nurse (LPN) 5.During an interview on 12/05/25 at 2:10 PM, LPN5 stated she was told about the incident between R1 and R8. LPN5 stated she would have told her supervisor immediately but didn't remember who she reported the incident to.During an interview on 12/03/25 at 4:10 PM, Licensed Practical Nurse Unit Manager (LPNUM) stated I was off. When I came in, I found out. The CNA who witnessed, reported the incident to me. I believe I was told just before dinner. I notified the DON [Director of Nursing] at the time I was notified. I called her. She came down and assessed the situation and determined that he [R8] needed to go to behavior health and notified social services.During an interview on 12/03/25 at 3:34 PM, the Director of Nursing (DON) stated I was not present, it happened over weekend. It was reported to me on 10/19. I believe the staff told me. The required reporting time frame is 2 hours. But I reported it as soon as I found out about it.3. Review of the intake form received from the SA and the facility's provided documentation of electronic submission to the SA regarding an allegation of witnessed physical abuse between R23 and R8 on 11/26/25 at 9:27 AM, revealed the SA received the report of the allegation of physical abuse on 11/26/25 at 1:52 PM.Review of the facility provided investigative documentation, dated 12/01/25, revealed a staff member witnessing R8 hit R23 on the arm intentionally on 11/26/25 at 9:27 AM.During an interview on 12/04/25 at 3:31 PM, LPN1 stated he informed the DON immediately of the incident.During an interview on 12/03/25 at 3:34 PM, the DON stated The required reporting time frame is 2 hours. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	But I reported it as soon as I found out about it.Review of the facility's policy titled, Abuse Prohibition / Reporting and Investigation updated April 2017, revealed The initial report of the incident will be faxed or emailed immediately but no more than 2 hours of abuse or an incident that results in serious injury or within 24 hourswhen there is no abuse or serious injury.

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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 interviews, record review, and policy review, the facility failed to develop a comprehensive care plan following victimization of abuse for two of 26 sampled residents (R) (R1 and R23).Findings included:1. Review of R1's Face Sheet located under the Resident tab of the electronic medical record (EMR), revealed R1 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis, major depressive disorder, dementia, and anxiety disorder.Review of R1's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/22/25, located in the RAI [Resident Assessment Instrument] tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of seven out of 15 which indicated severe cognitive impairment.Review of the facility provided undated investigative documentation, revealed a staff member witnessed R8 threatened to slap R1 and kill him and his family on 10/18/25 at 3:21 PM.Review of R1's Care plan located under the RAI tab of the EMR, revealed victimization of abuse was not addressed or the potential for psychosocial harm.2. Review of R23's Face Sheet located under the Resident tab of the EMR, revealed R23 was admitted to the facility on [DATE] with diagnoses which included schizophrenia, Alzheimer's disease, dementia, and cognitive communication deficit.Review of R23's quarterly MDS with an ARD of 08/22/25, located in the RAI tab of the EMR, revealed a BIMS score of three out of 15 which indicated severe cognitive impairment. Review of R23's Care plan located under the RAI tab of the EMR, revealed victimization of abuse was not addressed or the potential for psychosocial harm.During an interview on 12/04/25 at 2:03 PM, the Director of Nurses (DON) confirmed that victimization of abuse was not addressed in R1's or R23's care plans. The DON stated that she would expect to see a care plan and interventions related to being at risk for further abuse.Review of the facility's policy titled, Care Plans - Comprehensive Person-Centered, dated September 2017, indicated It is the intent of [Company Name] facilities to develop and implement a person-centered plan of care for each resident that includes goals for admission, discharge and desired outcomes.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and policy review, the facility failed to revise a comprehensive care plan following aggressions of abuse for one of 26 sampled residents (R) (R8). Findings included:Review of R8's Face Sheet located under the Resident tab of the electronic medical record (EMR), revealed R8 was admitted to the facility on [DATE] with diagnoses which included parkinsonism, schizoaffective disorder, bipolar disorder, anxiety disorder, history of traumatic brain injury, altered mental status, and schizophreniform disorder. R8 was discharged from the facility on 11/26/25.Review of R8's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/20/25, located in the RAI [Resident Assessment Instrument] tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated he was cognitively intact and had not exhibited any physical, verbal, or other behavioral symptoms towards others.Review of R8's Care plan located under the RAI tab of the EMR, dated 09/16/25, contained the following Problem area, Resident has verbal behavioral symptoms directed toward others (impulsive, whispers in residents' ears, unwanted interactions. The care plan's goal specified, Resident will not threaten, other residents, visitors, and/or staff. The care plan's approach for staff, dated 09/16/25, included, Allow distance in seating other residents around resident. Assess whether the behavior endangers the resident and/or others. Intervene if necessary. Avoid power struggles with resident. Maintain a calm environment and approach to the resident. Maintain a calm, slow, understandable approach. Praise resident when behavior is appropriate. Remove resident from group activities when behavior is unacceptable.Review of the facility provided undated investigative documentation, revealed a staff member witnessed verbal threats that R8 threatened to slap R1 and kill him and his family on 10/18/25 at 3:21 PM.Review of the facility provided investigative documentation, dated 12/01/25, revealed a staff member witnessing R8 hit R23 on the arm intentionally on 11/26/25 at 9:27 AM.Review of R8's Care plan, located under the RAI tab of the EMR, revealed no updated interventions to prevent R8 from abusing other residents.During an interview on 12/04/25 at 2:03 PM, the Director of Nursing (DON) stated direct care nurses or nurse managers were responsible for day-to-day care plan updates. DON confirmed R8's care plan had not been revised since the 10/18/25 and 11/26/25 incidents with interventions to prevent further abuse to other residents. The DON also stated that she would expect to see the current interventions on the care plan.Review of the facility's policy titled, Care Plans - Comprehensive Person-Centered, updated September 2017, indicated Care plans are revised as changes in the resident's condition dictates.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and facility policy review, the facility failed to ensure assistive devices and treatment were attempted for one of seven residents (R) (R69) reviewed for positioning/mobility. This had the potential for the residents to experience a further decline in range of motion (ROM). Findings included:Review of R69's Face Sheet located in the electronic medical record (EMR) under the Resident tab, revealed the resident was admitted to the facility on [DATE] with diagnosis of hemiplegia and hemiparesis (paralysis/loss of strength) following a cerebral infarction (stroke) affecting his right dominant side. Review of R69's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/24/25 and located in the EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) was unable to be completed. The resident was noted to be severely impaired for daily decision making. The MDS further revealed the resident had impaired ROM of the upper extremity and was not receiving specialized rehabilitation services. Review of R69's Care Plan with a start date of 02/10/22, located in the EMR under the Care Plan tab, revealed the resident had potential for pain/discomfort related to impaired mobility and contractures. The goal was the resident would demonstrate relief or reduction in pain intensity after receiving interventions through the review period. Interventions included administering pain medication and repositioning. Review of R69's Occupational Therapy Daily Note, dated 06/04/20 and provided by the facility, revealed the resident received passive stretching and was able to open his right hand for hand hygiene. R69 was participating without any complaints with moving his right upper extremity initially. With progression he withdrew his limb. The evaluation revealed that without Occupational Therapy (OT) the resident was at risk of further progression of contracture. Review of R69's Occupational Therapy Daily Note, dated 06/05/20 and provided by the facility, revealed the resident tolerated gentle passive movements and was agreeable for trialing a temporary splint (rolled wash cloth shaped as a carrot). The resident was able to hold on to the splint for five minutes, then after 30 minutes he took off the splint. On 06/08/20 and 06/10/20, R69 refused therapy services and was discharged from OT services. There were no documented recommendations made in order to potentially prevent the resident from a decline in ROM for his right wrist or any other device be attempted. Review of the [Name] Rehab Physician Order Request, dated 09/16/25 and located in the EMR under the Documents tab, revealed a request was made from OT for the resident to receive OT therapy three times a week for eight weeks for therapeutic activities and orthotic management and training. The order was approved on 09/17/25. During observations of R69 on 12/02/25 at 11:00 AM and 12/04/25 at 8:51 AM, it was revealed that the resident was in the common/dining area in his wheelchair. His right wrist was contracted, and his hand was closed. There was no splint or device in place. During an interview on 12/04/25 at 8:30 AM, the Occupational Therapy Assistant (OTA) revealed R69 was only seen for wheelchair positioning 09/16/25 and was discharged from OT therapy on 10/23/25. She confirmed the resident was not seen for any orthotic management for his right wrist contracture. She further confirmed there were no orders in place for a splint, brace, or any device for his wrist contracture. During an interview on 12/04/25 at 9:00 AM, Certified Nursing Assistant (CNA) 1 revealed she was often assigned to the care of R69. She confirmed she wasn't aware of any device to be used for his contracted right wrist. During an interview on 12/04/25 at 3:30 PM, the Director of Rehab (DOR) confirmed R69 was seen five years ago (June 2020) for his right wrist contracture and it was recommended the resident use a splint/device to help prevent worsening of the contracture. The DOR confirmed the resident was discharged from OT on 06/12/20. She revealed the goal was for the resident to tolerate (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115553	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER Magnolia Manor of Midway		STREET ADDRESS, CITY, STATE, ZIP CODE 652 North Coastal Highway 17 Midway, GA 31320	

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the splint for two to three hours per day. She confirmed he was discharged from OT therapy due to multiple refusals on 06/12/20. The DOR confirmed the last documentation regarding R69's right wrist contracture was five years, and nothing had been attempted since then. She confirmed there was an order dated 09/16/25 for orthotic management, however he was only seen for positioning in his wheelchair. Review of the facility's policy titled, Specialized Rehabilitative Services, revised November 2016, revealed Intent, it is the intent of [name of facility] to provide specialized rehabilitative services to meet the resident's needs and support the resident in attaining or maintaining their highest practicable physical, mental and psychosocial well-being.

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	115553	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Manor of Midway	652 North Coastal Highway 17 Midway, GA 31320

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interviews, and review of policies and procedures, the facility failed to assess the entrapment risk of bedrails used for mobility assistance and obtain consent for one of three residents (R) (R47) reviewed for accident hazards.Findings included:Review of R47's Face Sheet located under the Resident tab of the electronic medical record (EMR) revealed R47 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease and depression. Review of R47's quarterly Minimum Data Set (MDS) located under the RAI [Resident Assessment Instrument] tab of the EMR with an Assessment Reference Date (ARD) of 10/01/25, revealed R47 had Alzheimer's disease, no upper and lower extremity impairments, and was dependent on staff to help with rolling from side to side. It was recorded that R47 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated the resident was cognitively intact. Review of R47's Care plan located under the RAI tab of the EMR, dated 02/14/24, revealed focuses related to activities of daily living (ADLs) Functional Status/Rehabilitation Potential of impaired functional mobility. Goals included functional mobility, positioning and transfers will be achieved daily with use of appropriate devices with interventions that included bed mobility assist handles to bed bilaterally, dated 08/20/24.During an observation and interview on 12/02/25 at 11:46 AM, bilateral 1/8 side rails were on R47's bed. R47 stated she used the side rails to help herself reposition in bed. R47 demonstrated how she used the side rails to reposition.Review of R47's Physician's Orders located under the Resident tab of the EMR, revealed an order, dated 03/25/25, for Resident uses bilateral Grab Bars for bed mobility.Review of R47's side rail assessment, dated 12/28/23, provided by the facility, revealed Bed rails are not indicated at this time.Review of R47's Progress notes located under the Resident tab of the EMR, revealed a progress note, dated 12/01/25 at 9:48 AM, that included Bilateral upper and lower body weakness. Resident is able to grab bars and turn self without any injury.During an interview on 12/05/2025 at 12:07 PM, the Director of Nursing (DON) stated documentation regarding risks and benefits of bedrails discussed and a consent form were unable to be located.Review of the facility's policy titled, Restraints/Bed Rails, updated August 2018, indicated Prior to the use of bed rails the facility must: Attempt to use alternatives, Assess the resident for the risk of entrapment, Review the risks and benefits with the resident and resident representativeObtain consent.

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NAME OF PROVIDER OR SUPPLIER: Magnolia Manor of Midway		STREET ADDRESS, CITY, STATE, ZIP CODE: 652 North Coastal Highway 17 Midway, GA 31320	

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, review of the Centers for Disease Control and Prevention (CDC) guidelines, and facility policy review, the facility failed to ensure three of five residents (R) (R2, R6, and R69) reviewed for pneumococcal/flu vaccines was offered a pneumococcal and flu vaccine and were provided the risks and benefits for pneumococcal and flu vaccines. The facility failed to ensure that two of five residents (R3 and R75) were provided with the risks and benefits prior to receiving the pneumococcal vaccine. This had the potential for the residents to have an increased risk of contracting pneumonia and flu, and for those who received the pneumococcal and flu vaccines without consent, and providing the risks and benefits did not provide the residents and or representatives the right to make an informed decision before being given the pneumococcal vaccine. Findings included:1.Review of R2's Face Sheet located in the electronic medical record (EMR) under the Resident tab revealed the resident was admitted to the facility on [DATE] and was [AGE] years old.Review of the [name of facility] Vaccination Authorization form, dated 09/19/23 and provided by the facility, revealed R2's responsible party declined for R2 receive the pneumococcal and flu vaccine. There was no evidence in the medical record the responsible party received the risks and benefits prior to refusing the vaccines. Review of R2's Immunization Records located in the EMR under the Preventative Health Care tab, revealed the resident received the pneumococcal conjugate vaccine (PCV) 13 outside of the facility on 05/26/21 prior to her admission to the facility. There was no evidence that the resident was offered the PCV20 or PCV21 per recommendations of the CDC in order to be complete for the pneumococcal vaccine.Review of R2's EMR revealed there was no further documentation to show the resident/resident representative was given the opportunity besides at admission two years ago to receive the pneumococcal and/or flu vaccine.2. Review of R6's Face Sheet located in the EMR under the Resident tab revealed the resident was most recently admitted to the facility on [DATE] and was [AGE] years old. Review of the [name of facility] Vaccination Authorization form, dated 11/10/22 and provided by the facility, revealed R6's responsible party consented verbally via telephone for R6 to receive the pneumococcal and flu vaccine. There was no evidence in the medical record the responsible party received the risks and benefits prior to receiving the vaccines. Review of R6's immunization records located in the EMR under the Preventative Health Care tab, revealed the resident received the pneumococcal polysaccharide vaccine (PPSV) 23 outside of the facility on 06/22/22 prior to her admission to the facility. There was no evidence that the resident was offered the PCV15, PCV20, or PCV21 per recommendations of the CDC in order to be complete for the pneumococcal vaccine. The Immunization Records further revealed the resident received the flu vaccine on 10/03/25. The area of risks and benefits being provided was blank.3. Review of R69's Face Sheet located in the EMR under the Resident tab revealed the resident was admitted to the facility on [DATE] and was [AGE] years old. Review of the undated [name of facility] Vaccination Authorization form, provided by the facility, revealed R69's responsible party consented for R69 to receive the pneumococcal and flu vaccine and received the risks and benefits. Review of R69's Preventative Health Care document located in the EMR under the Preventative Health Care tab, revealed the resident received the PPSV23 at the facility on 11/11/21. There was no evidence that the resident was offered the PCV15, PCV20, or PCV21 per recommendations of the CDC in order to be complete for the pneumococcal vaccine. The immunization record further revealed the resident received the flu vaccine on 10/03/25.Review of R69's Preventative Health Care document located in the EMR under the Preventative Health Care tab, revealed the resident received the flu vaccine on 10/03/25. The area of risks and benefits being provided was blank.4. Review of R3's Face Sheet located in the EMR under the (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident tab revealed the resident was admitted to the facility on [DATE] and was [AGE] years old.Review of the undated [name of facility] Vaccination Authorization form, provided by the facility, revealed R3's responsible party consented for R3 to receive the pneumococcal and flu vaccine and received the risks and benefits. Review of R3's Preventative Health Care document located in the EMR under the Preventative Health Care tab, revealed the resident received the flu vaccine on 10/03/25 and the PCV20 on 09/19/25. The area of risks and benefits being provided was blank.5. Review of R75's Face Sheet located in the EMR under the Resident tab revealed the resident was admitted to the facility on [DATE] and was [AGE] years old. Review of the [name of facility] Vaccination Authorization form, dated 02/10/23 and provided by the facility, revealed R75's responsible party consented for R75 to receive the pneumococcal and flu vaccine. There was no evidence the responsible party received the risks and benefits prior to the administration of the vaccines. Review of R75's Preventative Health Care document located in the EMR under the Preventative Health Care tab, revealed the resident received the flu vaccine on 10/03/25 and the PCV20 on 09/19/25. The area of risks and benefits being provided was blank.During an interview on 12/04/25 at 10:45 AM, the Infection Preventionist (IP) confirmed the above findings. She revealed all of the resident's consents were obtained at the time of admission and no further up to date consents were obtained prior to the administration of the flu and pneumococcal vaccines. She further confirmed R2, R6, and R69 were not up to date with their pneumococcal vaccines and the residents' responsible parties were not contacted to obtain consents or refusals for the pneumococcal vaccines recommended by CDC.Review of the facility's policy titled, Infection Prevention and Control Program, revised February 2020, under Influenza and Pneumococcal Immunizations, revealed 1. Each resident or their resident representative must receive education regarding the benefits and potential side effects from Influenza or Pneumococcal Immunization.3. Each resident will be offered the Pneumococcal Vaccine on admission. 4. The resident or their representative have the right to refuse the immunization. 5. Documentation of immunization must include but not be limited to: A. Resident or resident representative was provided education regarding benefits and potential side effects of the immunization. B. If the resident received the immunization or did not receive it due to medical contraindications or refusal. Review of CDC guidelines, located at https://cdc.gov/acip-recs/hcp/vaccine-specific/pneumococcal.html and dated 01/08/25, revealed .Administer PCV15, PCV20, or PCV21 for all adults 50 years or older who have never received any pneumococcal conjugate vaccine, or whose previous vaccination history is unknown. Adults aged 50 years and older if a PPSV23 only was given, give a single dose of PCV21, PCV20, or PCV15 after one year after the last PPSV23 dose. If a PCV13 was only given, give a single dose of PCV21 or PCV20 one year after the PCV13 dose. If a PCV13 was given at any age and a PPSV23 at age [AGE] or older, it is recommended through shared clinical decision-making of either giving a single dose of PC21 or PCV20 for any adult aged 65 years or older who has completed the recommended vaccination series with both PCV13 and PPSV23. If decision to administer PCV21 or PCV20 is made, a single dose is recommended after five years after the last pneumococcal vaccine dose.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, review of the Centers for Disease Control and Prevention (CDC) guidelines, and facility policy review, the facility failed to ensure one of five residents (R) (R2) responsible party had received the risks and benefits explained before they declined for the resident to receive the COVID-19 vaccine/ booster. The facility failed to ensure that two of five residents (R6 and R75) responsible parties, received the risks and benefits before receiving the COVID-19 vaccine/booster. Additionally, the facility failed to ensure two of five residents (R69 and R3) responsible party were given the opportunity to make a decision if they wanted their residents to receive a COVID-19 vaccine/ booster. This had the potential for an increase in contracting COVID-19 and for the responsible parties not being provided with the risks and benefits in order to make an informed decision. Findings included:1.Review of R2's Face Sheet located in the electronic medical record (EMR) under the Resident tab revealed the resident was admitted to the facility on [DATE].Review of the [name of facility] Vaccination Authorization form, dated 09/19/23 and provided by the facility, revealed R2's responsible party declined for R2 to receive the COVID-19 vaccine/booster. There was no evidence in the medical record the responsible party received the risks and benefits prior to refusing the COVID-19 vaccine/booster. 2. Review of R6's Face Sheet located in the EMR under the Resident tab revealed the resident was most recently admitted to the facility on [DATE]. Review of the [name of facility] Vaccination Authorization form, dated 11/10/22 and provided by the facility, revealed R6's responsible party consented verbally via telephone for R6 to receive the COVID-19 vaccine/booster. There was no evidence in the medical record the responsible party received the risks and benefits prior to receiving the vaccine. R6 received the COVID-19 vaccine/booster on 11/17/25. The area of risks and benefits being provided was blank.3. Review of R75's Face Sheet located in the EMR under the Resident tab revealed the resident was admitted to the facility on [DATE]. Review of the [name of facility] Vaccination Authorization form, dated 02/10/23 and provided by the facility, revealed R75's responsible party consented for R75 to receive the COVID-19 vaccine/booster. Review of R75's Preventative Health Care document located in the EMR under the Preventative Health Care tab, revealed the resident received the COVID-19 vaccine/booster on 11/17/25. The area of risks and benefits being provided was blank.4. Review of R69's Face Sheet located in the EMR under the Resident tab revealed the resident was admitted to the facility on [DATE]. Review of the undated [name of facility] Vaccination Authorization form, provided by the facility, revealed no documented evidence the residents responsible party was given the opportunity or provided the risks and benefits so an informed decision could be made for obtaining the COVID-19 vaccine/booster for the resident. 5. Review of R3's Face Sheet located in the EMR under the Resident tab revealed the resident was admitted to the facility on [DATE]. Review of the undated [name of facility] Vaccination Authorization form, provided by the facility, revealed no documented evidence the resident's responsible party was given the opportunity or provided the risks and benefits so an informed decision could be made for obtaining the COVID-19 vaccine/booster. During an interview on 12/04/25 at 10:45 AM, the Infection Preventionist (IP) confirmed the above findings. She further revealed of the consents obtained for R2, R6, and R69 for the COVID-19 vaccine/booster, were obtained at the time of admission and no further up to date consents were obtained prior to the administration of the COVID-19 vaccine/booster. She confirmed the resident's responsible parties had the right to change their minds and should be asked again, as well as provided the education and risks as those change. Review of the CDC guidelines for COVID-19 boosters located at (continued on next page)

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	115553	A. Building B. Wing	12/05/2025

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	https://www.cdc.gov/covid/vaccines/long-term-care-residents.html, dated 06/11/25, revealed.CDC recommends everyone ages 65 years and older, including people who live and work in long term care (LTC) settings, get two doses of an updated COVID-19 vaccine six months apart.People who live in LTC setting must give consent or agree to getting a COVID-19 vaccine.Consent or assent for a COVID-19 vaccine is given by LTC residents (or people appointed to make medical decisions on their behalf, called a medical (proxy) and documented in their charts per the provider's standard practice. Residents who receive a COVID-19 vaccine (or their medical proxy) also receive a fact sheet before vaccination. The fact sheet explains the risks and benefits of COVID-19 vaccination.Review of the facility's policy titled, Infection Prevention and Control, revised February 2020, revealed Intent, it is the intent of [name of 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. The policy did not address COVID-19 vaccine boosters.