Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063007	A. BUILDING: _____ B. WING _____	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GARDENS	594 MURRAY HILL ROAD SOUTHERN PINES, NC 28387

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Moore County Department of Social Services conducted an annual survey on January 8-9, 2025.	D 000		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide feeding assistance to a resident (#8) immediately upon receipt of her meal. The findings are: Review of Resident #8's current FL-2 dated 05/02/24 revealed diagnoses included muscle weakness, dysphagia, depression, and Alzheimer's disease. Observation during the breakfast meal on 01/09/25 between 7:50am and 8:36am revealed: -Resident #8 had her food in front of her and a tall pink cup to the right of her in reaching distance. -There were grits, scrambled eggs, sausage and bacon cut into bite size pieces on her plate. -A slice of toast was sitting on a napkin next to the resident. -A personal care aide (PCA) was sitting next to Resident #8. -At 7:50am the PCA got up from next to Resident	D 312	Magnolia Gardens will ensure that all feeders will be feed timely. Once a feeder is position and food is delivered staff should start feeding within 3-5 mins. Staff should complete the feeding before leaving resident, unless an emergency occurs. In House training provided to all PCA's and Med Techs. Training included Personal Care Aid Nutrition and Alz Disease. Restorative Eating/Feeding Completion 01/29/2025 by HR Director and ED. (ED is approved NC PCS trainer) QA/QI will be monitored by Care Coordinator and Special Care unit Manager. One meal will be supervised weekly in both AL and SCU. Effective 01/29/25.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Debbie Ogburn | TITLE: President | (X6) DATE: 01/29/2025

RECEIVED AND ACKNOWLEDGED ON 01/30/25 BY NURSE CONSULTANT

Tina B Nielsen

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#8 to assist with another resident and came back.
-At 7:51am the PCA got up from next to Resident #8 to assist with another resident.
-Resident #8's food was still in front of her, but the resident was not eating.
-At 7:55am, the PCA who was sitting next to Resident #8 had not returned to assist the resident with feeding; her food was in front of her, but she was not eating.
-At 7:55am, two PCAs in the dining room (including the one who sat next to Resident #8) were removing plates from other tables as residents finished their food in the dining room.
-At 7:59am, Resident #8 attempted to pick up her cup but was unsuccessful.
-At 8:00am, a third PCA sat next to Resident #8 and began assisting her with feeding.
-At 8:02am, the third PCA got up from the table while assisting Resident #8 with feeding to assist another resident.
-The other two PCAs continued to remove plates from the tables.
-Resident #8 sat there while the third PCA helped the other resident and did not attempt to eat her food on her own.
-At 8:03am the third PCA returned to offer feeding assistance to Resident #8.
-At 8:07am a call bell from another resident sounded and the third PCA got up from feeding Resident #8 and went into the hallway to see where the assistance was needed and returned.
-The other two PCAs in the dining room continued to remove plates from the tables.
-At 8:14am, the third PCA continued to feed Resident #8, and another resident started grabbing at Resident #8's plate.
-At 8:16am the third PCA got up from feeding Resident #8 and escorted the other resident to her table, while a second PCA watched.
-The first PCA continued to remove plates from

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other tables and started to clean the tables.
-The third PCA helped the other resident to her wheelchair and told the resident, "I got to help Resident #8, I'll be back."
-The other resident grabbed the third PCA's hand and would not let her go.
-At 8:19am, Resident #8 attempted to pick up her cup but was unsuccessful.
-The third PCA then pushed the resident, she redirected, in her wheelchair to the table where Resident #8 was still sitting with her food in front of her, not eating and began feeding Resident #8.
-At 8:21am, the second PCA walked by the resident attempting to get up from her wheelchair at the table where the third PCA was feeding Resident #8.
-At 8:36am Resident #8 finished her meal and ate 100% of her food.

Interview with the first PCA on 01/09/25 at 8:25am revealed:
-Resident #8 fed herself some days.
-He did not know why he sat next to Resident #8 and did not feed her.

Interview with the third PCA on 01/09/25 at 8:20am revealed:
-She sat down next to Resident #8 because she saw she needed help.
-The other PCAs in the dining room were expected to help each other redirect the residents if another PCA was offering feeding assistance to a resident.
-She did not know why the other PCAs did not help her with redirecting the other resident while she was feeding Resident #8.

Interview with the Administrator on 01/09/25 at 9:31am revealed:
-She expected staff to offer feeding assistance to

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D 312	Continued From page 3 the residents when they could not feed themselves. -Once staff started to feed a resident, they should not get up from feeding unless there was an emergency.	D 312		