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 _____	R-C 12/05/2025

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 conducted an annual and follow-up survey and complaint investigation on 12/02/25 - 12/05/25. One of the complaint investigations was initiated by the Moore County Department of Social Services on 11/19/25.	D 000		
D 067	10A NCAC 13F .0305 (h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In facilities with at least one resident who is determined by a physician or is otherwise observed by staff to be disoriented or exhibits wandering behavior, a continuously sounding device that is activated when the door is opened shall be located on each exit door that opens to the outside. The sound shall be audible in the facility. If a central system of remote sounding devices is provided, the control panel shall be powered by the facility's electrical system, and be in a location accessible by staff to operate the control panel. Notwithstanding the requirements of Rule .0301, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by. Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 3 exit doors accessible to residents who were assessed to be confused or disoriented, had working door alarms that were of sufficient volume that could be heard by staff when activated and responded	D 067		

Reviewed and Acknowledged
WW 01/30/26

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D 067	Continued From page 1 to for the safety of the residents. The findings are: Review of the facility's current license dated 01/01/25 revealed the facility was licensed as an assisted living (AL) facility with a capacity of 78 beds in the AL section, and 32 beds in the secured special care unit (SCU). Observation of the AL 200 hall on 12/02/25 at 9:59am revealed: -The exit door close to room 202 was unlocked. -There was no audible sound heard when the door was opened or closed. -There was a sensor with a glowing green light attached to the corner of the wall next to the door. Observation of the facility on 12/02/25 at 10:13am revealed the Maintenance Director opened the 200 hall exit door and there was no audible sound heard. Observation of the AL 300 and 400 halls on 12/02/25 at 10:10am revealed: -There was a sign on both exit doors on the 300 and 400 halls that read "alarm will sound". -No alarm sounded when the doors to the facility were opened and closed. -There were sensors with a glowing green light attached to the wall next to the doors. Second observation of the AL 300 and 400 halls on 12/04/25 at 8:25am revealed: -A loud, intermittent beeping noise sounded at a panel at the nurse's station when the doors were opened. -The alarm sounded continuously until a staff member opened the security panel and turned the alarm off.	D 067	Magnolia Gardens management team will alarm all exit doors when a resident is showing signs of disorientation or exhibits wandering behaviors. Care Coordinators, AD and ED. will perform 5 audits weekly on nursing notes, incident reports, H&P's, and interdisciplinary notes. Alarms will be monitored daily once resident is identified. (FL2's Care Plans and Resident Registry will be included in the weekly audits).	12/06/25

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D 067	Continued From page 2 1. Review of Resident #2's current FL-2 dated 04/09/25 revealed: -Diagnoses included dementia, diabetes type II, diabetic neuropathy, chronic kidney disease, history of stroke, and hypertension. -There was a checkmark placed next to "intermittently" in the section titled "disoriented". Review of Resident #2's care plan and assessment dated 04/09/25 revealed: -Resident #2 was assessed to be oriented. -Resident #2 was forgetful and needed reminders. Review of Resident #2's Resident Register dated 06/01/23 revealed: -Resident #2 was admitted to the facility on 06/01/23. -Assistance required for Resident #2 included orientation to time and place. -Resident #2 was forgetful and needed reminders. Review of psychiatric follow-up notes dated 09/10/25 and 10/08/25 revealed: -Resident #2's intellectual insight was impaired. -Resident #2 was oriented to person and time. -Resident #2 had some difficulty recalling basic orientation questions. Interview with Resident #2's mental health provider (MHP) on 12/03/25 at 9:43am revealed: -Resident #2's memory was declining. -She considered Resident #2 to have moderate dementia. -Resident #2 would not be good in giving details and remembering details and was a poor historian.	D 067		

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D 067	Continued From page 3 Second interview with Resident #2's MHP on 12/05/25 at 11:33am revealed: -Resident #2's orientation status was not good. -Resident #2 had a "disconnect with time". Refer to interview with the Maintenance Director on 12/02/25 at 10:13am. Refer to interview with the Housekeeping Supervisor on 12/04/25 at 8:30am. Refer to interview with the Administrator on 12/03/25 at 5:45pm. Refer to second interview with the Administrator on 12/05/25 at 10:26am. 2. Review of Resident #3's current FL-2 dated 10/22/25 revealed: -Diagnoses included aneurysm, right-sided weakness, and expressive aphasia. -The resident was intermittently disoriented. Observation of Resident #3 on 12/02/25 at 10:00am revealed: -She had difficulty expressing herself verbally or responding to questions. -She was able to verbalize needs through a combination of speaking and tracing letters on her stomach with her finger. Interview with Resident #3's mental health provider (MHP) on 12/05/25 at 11:33am revealed: -Resident #3 was oriented to person, place, and time on her visits. -She had difficulty communicating due to expressive aphasia from an aneurysm. Refer to interview with the Maintenance Director on 12/02/25 at 10:13am.	D 067		

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D 067	Continued From page 4 Refer to interview with the Housekeeping Supervisor on 12/04/25 at 8:30am. Refer to interview with the Administrator on 12/03/25 at 5:45pm. Refer to second interview with the Administrator on 12/05/25 at 10:26am. Interview with the Maintenance Director on 12/02/25 at 10:13am revealed: -The exit door alarm was "not on right now". -The exit door alarms were typically not on during the day and were turned on at 8:00pm or 9:00pm. -Exit door alarms were turned on during the day if there was bad weather. -The only doors that were alarmed at all times were the two doors on the SCU and the back door to the service area/dumpster. -There was a resident in the assisted living (AL) section of the facility that had a wander guard monitor and there would be an audible alarm sounded when the wander guard monitor got close to an exit door. -Staff had to physically reset the wander guard sensor/receiver at the exit door once the alarm sounded. Interview with the Housekeeping Supervisor on 12/04/25 at 8:30am revealed: -The front door also alarmed at the 300 and 400 hall nurse's station alarm panel. -The alarm sounded at the panel until physically turned off at the panel by a staff member. Interview with the Administrator on 12/03/25 at 5:45pm revealed: -She now understood that Residents #2 and #3 were determined to be intermittently disoriented	D 067		

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D 067	Continued From page 5 and that the facility exit doors should always be alarmed. -Staff would be made immediately aware that all exit doors had to be alarmed at all times. Second interview with the Administrator on 12/05/25 at 10:26am revealed: -She had not reviewed all the residents' FL-2s that had been living at the facility for a while. -The care coordinators were responsible for reviewing residents' FL-2s. -The facility exit doors were alarmed "most of the time". -The exit doors of the facility were in view of the camera system installed at the facility. -She did not think there were any residents in the AL section of the facility who were disoriented.	D 067		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure physician notification for 2 of 7 sampled residents (#1, #6) regarding behaviors (#1) and for a resident who had recommendations from hospice for the use of devices to preserve skin integrity (#6). The findings are: 1. Review of Resident #1's current FL-2 dated 11/22/25 revealed: -Diagnoses included history of falls, hypertension,	D 273	Magnolia Gardens Care Coordintors will ensure that all residents referrals and follow-ups are completed. All orders for medication, DME equipment, specialized doctors, Home Health and Hospice orders will be followed by the CC's. The Lead Care Coordinator, ED and AD will audit 5 resident carts monthly for compliance. Resident referral and follow-ups are to include behavior changes.	1/21/26

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D 273	Continued From page 6 atrial fibrillation, alcohol disorder, hypokalemia, gastroesophageal reflux disease, and acute transaminitis. -There was no information provided for orientation status. Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 08/28/25. Review of Resident #1's care plan dated 08/29/25 revealed: -Resident #1 was assessed to be sometimes disoriented. -The resident was forgetful and needed reminders. Review of Resident #1's hospital discharge summary dated 08/28/25 revealed: -Resident #1 presented to the local hospital emergency department (ED) on 08/02/25 status post a ground level fall with head trauma. -The resident "was noted to be slightly confused". -The resident lacked some safety awareness and was often impulsive at times to move quickly when she got out of bed. Review of facility progress notes for Resident #1 revealed: -On 08/28/25, staff documented the resident arrived at the facility with a family member, could basically do for herself but would "need help with remembering things". -On 08/30/25, the resident was cursing at staff and other residents. -On 10/12/25, the resident was "very" confused and wanted to call the police. -On 10/19/25, the resident was seen at the local hospital ED and prescribed an antibiotic for treatment of a urinary tract infection.	D 273		

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D 273	Continued From page 7 -On 11/17/25, staff heard an alarm sound, Resident #1 went outside, resident stated she was looking for her car to go to a local department store, resident could not be redirected back inside the facility by staff, resident cursed and fussed with staff, and resident started walking toward the sidewalk away from the facility. Emergency service (911) was called for assistance. -On 11/23/25, staff documented the resident was setting an alarm (type of alarm not specified) off every 10 to 20 minutes. -There was no documentation that Resident #1's primary care provider (PCP) had been notified of behaviors exhibited by Resident #1. Observation of Resident #1 on 12/02/25 at 10:41am revealed: -The resident was walking in the 200-hall area of the facility. -There was a wander guard bracelet around Resident #1's right wrist. -There was a yellow bracelet around Resident #1's left wrist. Second observation of Resident #1 on 12/03/25 at 8:03am revealed the resident exited the dining room and asked a staff where her room was located. Interview with Resident #1 on 12/02/25 at 10:41am revealed the bracelet on her right wrist was to keep her from getting out of the facility. Second interview with Resident #1 on 12/02/25 at 4:45pm revealed: -She was recently admitted to the facility. -Her family placed her at the facility. -She liked to walk and used to walk for miles everyday before she was admitted to the facility.	D 273		

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D 273	Continued From page 8 Interview with a medication aide (MA) on 12/05/25 at 10:10am revealed: -She thought Resident #1 was confused. -When Resident #1 was first admitted, she saw the resident walking toward the facility on the sidewalk next to the road in front of the facility. -Resident #1 said she was "just going for a walk". -She thought the wander guard monitor was placed on Resident #1 right after that day (no specific date provided). Interview with a second MA on 12/05/25 at 11:00am revealed: -Resident #1 would get lost finding her room and was constantly asking where her room was located. -The staff did not think it was likely that Resident #1 would be able to find her way back to the facility if she walked away. Interview with the Lead Care Coordinator (LCC) on 12/03/25 at 10:16am revealed: -She was not present when the wander guard monitor bracelet was placed on Resident #1. -The Administrator usually determined which resident needed a wander guard monitor. -She could not recall if the facility had ever received a physician's order for a wander guard monitor placement. -She had not known a wander guard monitor to be removed from a resident in the past unless the resident had shown themselves not to be a safety risk, which meant not going away from the facility toward the highway, which placed them at risk for being hit. -She had not contacted the PCP about Resident #1 exiting the facility. Interview with the Human Resources/Assistant	D 273		

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D 273	Continued From page 9 Director (HR/AD) on 12/05/25 at 4:50pm revealed: -The MAs could call PCPs, especially if there was an incident. -The initial responsibility was with the MAs with regards to the reporting and follow-up of incidents. -Incident reports were completed for behaviors. -She would expect the MAs to report behavioral incidents to the PCP before the end of their working shift after an incident report was completed. -The PCP contact was important so the PCP could provide input regarding the resident. Interview with the Administrator on 12/02/25 at 4:55pm revealed: -She placed the wander guard bracelet on Resident #1 for precautions because she was unfamiliar to the facility. -Resident #1 recently had a urinary tract infection and "was a little confused". -Resident #1 would go out the exit doors and walk around the facility. -The facility was using the wander guard to learn Resident #1's behaviors. Second interview with the Administrator on 12/05/25 at 6:35pm revealed: -The MAs were responsible for referring the behavioral incident for Resident #1 to the PCP. -She would expect the PCP to be contacted by the MA for follow-up. Telephone interview with Resident #1's PCP on 12/03/25 at 5:05pm revealed: -Resident #1 was deemed an elopement risk when she was hospitalized. -A sitter was often at the resident's bedside when hospitalized.	D 273		

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D 273	Continued From page 10 -Resident #1 was still an elopement risk. -He was usually informed by the facility internal document if a resident left the facility, but he did not remember knowing about Resident #1 leaving the facility. -Resident #1 should not be able to walk outside the facility without someone in attendance. -If he had known, he would have told the staff not to allow Resident #1 to walk outside the facility alone. -He had not been made aware of any incident with Resident #1 by a phone call. -The facility might have sent a faxed report to him, but he did not recall signing anything. -He did not consider a wander guard a restraint and concurred with Resident #1 wearing a wander guard monitor. 2. Review of Resident #6's current FL-2 dated 09/15/25 revealed: -Diagnoses included Alzheimer's disease, acute posthemorrhagic anemia, other dysphagia secondary, anxiety, unspecified fall subsequent encounter, other abnormalities of gait and mobility, osteoarthritis, depression, cognitive communication deficit, muscle weakness, dysphagia unspecified, and other reduced mobility. -Special Care Unit (SCU) was the recommended level of care. Review of Resident #6's Resident Register revealed Resident #6 was admitted to the facility on 06/22/22. Review of an incident/accident report dated 07/14/25 revealed: -The incident occurred on 07/14/25 at 5:45am. -Resident #6 was being transported from bed to chair by medication aide (MA) and personal care	D 273		

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D 273	Continued From page 11 aide (PCA). -Resident #6's leg bumped against the chair which caused her skin to tear. -There was a skin tear to the left arm and a skin tear to the left leg documented. -There was no documentation that a physician was notified. -There was no documentation that a family member was notified. Review Resident #6's hospice nurse notes dated 07/15/25 revealed: -The nurse was notified by the hospice aide that the resident had several new skin tears and bruises. -Staff were unsure what happened. -The charge manager at the hospice agency and a staff member at the facility were notified. -Resident #6's right leg had a bruise 4 centimeters by 2.3 centimeters. -Resident #6's right leg had a skin tear 2.5cm by 2cm. - Resident #6's right arm had a skin tear 2cm by 2cm. -There was bilateral bruising on the hands and bilateral bruising on the feet of Resident #6. -There was a bruise on the right wrist. -Geri sleeves would be ordered to protect Resident #6's arms. -Resident #6 had a contracted left arm. -A carrot would be ordered for Resident #6 (a carrot is a device that can be placed in a contracted hand to preserve skin integrity). Observation of Resident #6 on 12/03/25 at 10:35am revealed: -Resident #6 was resting in her wheelchair in the common area. -Resident #6 had protective boots on both legs. -Resident #6 was not wearing geri sleeves and	D 273		

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D 273	Continued From page 12 did not have a carrot in her hand. Interview with the hospice licensed practical nurse (LPN) on 12/03/25 at 10:10am revealed: -Resident #6's geri sleeves and carrot were not on currently, but her arms looked good. -Her geri sleeves should be applied in the morning and off at night. -Resident #6's carrot should be used in the morning and taken out at night, but Resident #6 could use them at night. -Resident #6's geri sleeves were on at times when she arrived, and the carrot was usually in her hand. -She would ask staff if the sleeves were not in place. -The carrot was in place due to a hand contracture, and to prevent further contracture. -The sleeves were to prevent skin tears and bruising. -There was a minor skin tear here and there if the geri sleeves were not on. -Geri sleeves were put in place after the July 2025 skin tears. Interview with a PCA in Resident #6's room on 12/03/25 at 10:36am revealed: -She found Resident #6's carrot in the dresser. -The carrot was usually in Resident #6's right hand. -She had not seen the geri sleeves on Resident #6 in a month or more. -Resident #6 had not been wearing her geri sleeves. Second interview with the hospice LPN on 12/03/25 at 10:44am revealed: -She did not know when she last saw the geri sleeves on Resident #6. -When items were ordered, they were usually	D 273		

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D 273	Continued From page 13 brought to the facility by the nurse that ordered them. -At some point in the last two months, she had seen the geri sleeves. Observation of Resident #6 on 12/04/25 from 11:01am to 11:02am revealed: -She was sitting in the common area in her wheelchair with protective boots on. -Her carrot was not in her hand, and she was not wearing geri sleeves. -The PCA slowly opened the resident's left hand and placed the carrot. -The resident made a vocalization and withdrawal as if experiencing a temporary increase in pain. Interview with a PCA on 12/04/25 at 11:02am revealed the hospice aide gave Resident #6 a shower this morning and forgot to place the carrot in her hand. Observation of Resident #6 on 12/04/25 at 4:19pm revealed: -The resident was sitting in the common area by the TV with a carrot in her left hand. -She did not have geri sleeves on. -She had protective boots on both legs. Confidential interview with a staff member revealed: -She did not recall Resident #6 having geri sleeves or orders for geri sleeves. -Most of the time, they did not receive orders from hospice before they were sent to the pharmacy or the supplier. -Everything needed an order because the order would give facts of why it was needed or what benefits were, or how to use it. -Staff knew how to use the carrots, there could be an order.	D 273		

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D 273	Continued From page 14 Review of a clinical and hospice aide documentation sheet for Resident #6 dated 07/16/25 revealed: -The nurse case manager recommended geri sleeves for Resident #6 on 07/15/25. -The order was not obtained, therefore, no order for geri sleeves was entered. -The note was signed without a date next to the signature. Review of a clinical and hospice aide documentation sheet for Resident #6 dated 07/16/25 revealed: -The nurse case manager recommended geri sleeves for Resident #6 on 07/15/25. -The order was not obtained, therefore, no order for geri sleeves was entered. -The note was signed with the date 12/03/25 by the signature. Telephone interview with a hospice care manager for Resident #6 on 12/05/25 at 10:04am revealed: -No order was made for the geri sleeves, and she wrote a document back-dated 07/16/25, but just wrote the document on 12/03/25. -She would send a document clarifying that it was written Wednesday, 12/03/25. -The carrots were ordered from a durable medical equipment supplier, and she did not know if there was an order. -They would write an order for something like compression socks, but not for the use of the carrot. -They would teach staff how to place the device; an order could have information about how to clean the hand. Interview with the Special Care Coordinator (SCC) on 12/03/25 at 11:00am revealed:	D 273		

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D 273	Continued From page 15 -She had not seen Resident #6's geri sleeves since she became the SCC at the end of August 2025. -She would have to be more aware of what was ordered. -She did not know to ask about the sleeves. -She knew about Resident #6's boots and carrot. -The sleeves would help to protect Resident #6's arms from getting hit on the wheelchair with transfers and prevent skin tears. -She would try to put a name on Resident #6's sleeves and keep track of them because things could get lost easily. Second interview with the SCC on 12/05/25 at 8:50am revealed: -The carrot was to be used as needed, and she did not know if there was an order. -It was possible hospice trained staff on the carrot and sleeves. -She would call the hospice nurse and ask how to use the carrot and sleeves. -Inconsistent use of the carrot and sleeves was a problem. -Some staff did not pay attention to detail. -She could not hold them accountable without an order. -PCAs should check to see that the nails of Resident #6's left hand were not touching her skin. -The PCAs were not consistent enough, making sure that the carrot was in Resident #6's left hand every day. -She thought that the purpose of the carrot was to keep the resident's fingernails off of the skin. Interview with the Lead Care Coordinator (LCC) on 12/03/25 at 11:15am revealed: -Staff should let the SCC know that the Resident #6 did not have the sleeves.	D 273		

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D 273	Continued From page 16 -The SCC should have gotten new sleeves. -A recommendation was like an order in her eyes. -The staff could also order extra sleeves. -Sleeves would protect against skin tears and maybe not bruising. -There was training with staff and a physical therapist on transferring residents appropriately. -Things had improved since the training and Resident #6 had not had skin tears. Interview with the Administrator on 12/03/25 at 11:38am revealed: -The transfer training was either mid-June or mid-July and things got a lot better after that. -When staff were hired, they went through licensed healthcare personnel support training to go over transfers and skin care. -The geri sleeves were done for a while and then discontinued because Resident #6's wound was healed. -Normally the sleeves were worn for about two weeks. -She would check if there was an order for the sleeves. -If there was a recommendation but not an order from hospice, facility staff should tell the hospice nurse to talk with the primary care provider (PCP) about an order. -The sleeves should be on Resident #6 properly and there should be training. -The sleeve was to be placed on the skin tears until they healed. Interview with the Administrator on 12/05/25 at 12:22pm revealed: -The process of coordination was to talk to nurses and nurse aides with hospice. -Typically, the hospice nurse would give orders, but there was not an order for the sleeves. -The concern was that they were not getting all	D 273		

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D 273	Continued From page 17 the documentation. -She met with the hospice director with concerns that hospice nurses were telling staff what to do. -She was concerned that they had brought a bed alarm for a resident. Telephone interview with the PCP for Resident #6 on 12/03/25 at 3:29pm revealed: -She saw Resident #6 on 06/30/25 and did not make note of a skin tear or concern. -She could not recall if she ordered geri sleeves, but hospice could have ordered them through their physician. -Sometimes geri sleeves could be helpful and could protect from a skin tear, but skin tears could still happen. -She did not remember seeing the sleeves. -Resident #6 had fragile skin and minimal fat and elasticity to protect the skin. -The sleeves may or may not protect from skin tears and Resident #6 could still have shearing injuries. Attempted telephone interview with the responsible party for Resident #6 on 12/05/25 at 10:48am was unsuccessful.	D 273		
D 355	10A NCAC 13F .1003 (d) Medication Labels 10A NCAC 13F .1003 Medication Labels (d) Non-prescription medications shall have the manufacturer's label with the expiration date visible, unless the container has been labeled by a licensed pharmacist or a dispensing practitioner. Non-prescription medications in the original manufacturer's container shall be labeled with at least the resident's name and the name	D 355		

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D 355	Continued From page 18 shall not obstruct any of the information on the container. Facility staff may label or write the resident's name on the container. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a non-prescription medication was labeled with the resident's name and medication administration instructions for 1 of 7 (#4) sampled residents. The findings are: Review of Resident #4's current FL-2 dated 03/31/25 revealed diagnoses included mental disability, chronic constipation, and epilepsy. Review of Resident #4's physicians' orders dated 08/20/25 revealed there was an order for Bisacodyl 5mg give 1 tablet every other day. (Bisacodyl is used to treat constipation.) Review of Resident #4's electronic medication administration records (eMAR) for November 2025 and December 2025 revealed: -Resident #4 refused to take Bisacodyl 5mg 8 of 13 opportunities in November and December. -Bisacodyl 5mg was administered on 11/30/25 at 9:00am on the eMAR. Observation of Resident #4's medications on hand on 12/03/25 at 10:55am revealed: -There was a medication bubble-pack card in Resident #4's medications with the label torn off. -The card contained 12 small, orange tablets imprinted with the number 5.	D 355	Magnolia Gardens Med-Techs will ensure that all residents medications are labeled with Name and directions. Medications will either be in original containers or have a label for directions from Pharmacy. Lead Care Coordinator and Care Coordinator's will audit 5 residents medications weekly to ensure compliance.	12/8/25

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D 355	Continued From page 19 Interview with a medication aide (MA) on 12/03/25 at 11:00am revealed: -The unlabeled medication card contained Bisacodyl 5mg. -She did not know why the medication card was not labeled and had not noticed it previously. -Resident #4 often refused to take Bisacodyl 5mg. Interview with Resident #4 on 12/03/25 at 11:05am revealed: -She tore the label off the medication card herself when she was out of the facility on leave from 11/26/25 to 11/30/25. -The medication was for her bowels and she did not take the medication any longer. -She tore the label off the medication because she would not take it again. Interview with the Lead Care Coordinator (LCC) on 12/03/25 at 12:48pm revealed: -She was shown the medication card with the label torn off on 11/30/25 and she instructed the MA to order a new card of Bisacodyl for Resident #4 from the pharmacy. -The MA did not follow her instructions and obtain a labeled medication card. -The MA on 11/30/25 should not have administered the Bisacodyl to Resident #4 that day because the medication was not labeled. -Administering a medication to a resident that was not labeled properly could cause harm to a resident. Interview with the Administrator on 12/04/25 at 10:40am revealed: -She was not aware that there was a medication that was unlabeled with Resident #4's medications. -Staff should never administer a medication that	D 355		

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D 355	Continued From page 20 is unlabeled or place an unlabeled medication on the medication cart. -Staff could not properly confirm they were administering the right medication without a label on the medication.	D 355		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 3 residents (#8) observed during the medication pass including errors with an eye vitamin supplement used for macular degeneration and a vitamin supplement for Vitamin B12 deficiency and for 1 of 7 residents (#7) sampled for record review for an error with a nasal spray used to treat seasonal allergy symptoms. The findings are: 1. The medication error rate was 7% as evidenced by 2 errors out of 26 opportunities during the 8:00am medication pass on 12/03/25. a. Review of Resident #8's current FL-2 dated 03/10/25 revealed:	D 358	Magnolia Gardens Care Coordinators will ensure that all new and discontinued medication orders are faxed/electronically sent to the pharmacy the same day received. Medication will be verified by CC's in the eMAR within 24 hours. Med-Techs will ensure that the medication is stocked or pulled off the med cart. Lead Care Coordinator and Care Coordinator's will audit 5 residents medications monthly to ensure compliance.	1/22/26

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D 358	Continued From page 21 -Diagnoses included dementia, hypertension, and gastroesophageal reflux disease. -There was an order for Vitamin B12 1000mcg 1 tablet once daily. (Vitamin B12 is used to treat Vitamin B12 deficiency.) Review of Resident #8's lab results dated 06/11/25 revealed the resident's Vitamin B12 level was > (greater than) 2000 (reference range 213 - 816). Review of Resident #8's primary care provider (PCP) order dated 07/15/25 revealed: -There was an order to discontinue Vitamin B12. -There were instructions to send the order to the pharmacy to remove it from the medication list. -There was a red stamp imprint on the top right corner of the page with the word "faxed" and a space to document the date the order was faxed. -There was no date recorded of when the order was faxed to the pharmacy. Review of Resident #8's signed physicians' order sheet dated 10/22/25 revealed Vitamin B12 1000mcg continued to be listed on the resident's set of orders. Review of Resident #8's physician's orders and progress notes revealed no documentation the facility contacted the PCP to clarify Vitamin B12. Observation of the 8:00am medication pass on 12/03/25 revealed: -The medication aide (MA) prepared and administered one Vitamin B12 1000mcg tablet when the resident received her other morning medications at 7:34am. -Vitamin B12 1000mcg was administered after the order had been discontinued on 07/15/25.	D 358		

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D 358	Continued From page 22 Review of Resident #8's July 2025 - December 2025 electronic medication administration records (eMARs) revealed: -There was an entry for Vitamin B12 1000mcg 1 tablet once daily scheduled at 8:00am on the eMARs for each month. -Vitamin B12 was documented as administered from 07/01/25 - 12/03/25. -There was no documentation of Vitamin B12 1000mcg being discontinued from the eMAR when it was ordered to be discontinued on 07/15/25. Observation of Resident #8's medications on hand on 12/03/25 at 10:50am revealed: -There was a supply of Vitamin B12 1000mcg tablets dispensed on 11/08/25 with instructions to take 1 tablet daily. -There were 14 of 30 tablets remaining. Interview with the MA on 12/03/25 at 10:51am revealed: -She administered Vitamin B12 to Resident #8 because it was on the eMAR and in the medication cart. -She did not recall Resident #8's Vitamin B12 being discontinued. Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/03/25 at 3:00pm revealed: -The pharmacy staff entered orders into the facility's eMAR system when received, including orders to discontinue medications. -The facility staff were responsible for approving orders entered into the eMAR system. -The pharmacy never received an order to discontinue Resident #8's Vitamin B12 tablet, which is why it was not removed from the eMAR or physician's order sheet.	D 358		

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D 358	Continued From page 23 Interviews with the Lead Care Coordinator (LCC) on 12/03/25 at 12:10pm and 2:29pm revealed: -The Care Coordinators were responsible for faxing orders to the pharmacy, usually on the same day the order was received. -The red "faxed" stamp was used by the facility to document when an order was faxed to the pharmacy. -If there was no faxed stamp dated recorded, the order was probably not faxed to the pharmacy. -The pharmacy usually entered orders into the eMAR system, and the Care Coordinators were responsible for reviewing and verifying the orders in the eMAR system. -The Care Coordinators were responsible for giving discontinued medication orders to the MAs and the MAs were supposed to pull the discontinued medication and send it back to the pharmacy. -It appeared Resident #8's order to discontinue Vitamin B12 was never sent to the pharmacy so the medication was never stopped as ordered. -The Care Coordinators were responsible for following up with the pharmacy if an order was not entered into the eMAR system. -She spoke with Resident #8's PCP today, 12/03/25, and verified Resident #8's Vitamin B12 should have been discontinued in July 2025. Interview with the Administrator on 12/03/25 at 12:34pm revealed: -The Care Coordinators were responsible for faxing all new medication orders, including discontinued orders to the pharmacy, except for orders sent to the pharmacy electronically by a provider. -The Care Coordinators were responsible for approving orders in the eMAR system. -The Care Coordinators conducted medication	D 358		

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cart audits monthly and chart audits quarterly.
-She also did random medication checks quarterly.

Telephone interview with Resident #8's PCP on 12/03/25 at 3:29pm revealed:
-Resident #8's Vitamin B12 level was elevated on 06/11/25.
-She wanted the level to be high so when she discontinued the Vitamin B12 tablet, the resident's Vitamin B12 level should have gone back down and stayed in the normal range.
-She was not aware Vitamin B12 continued to be included on the resident's medication list on the physicians' order sheets.
-No one from the facility had contacted her regarding Resident #8's Vitamin B12 orders prior to today, 12/03/25.
-Resident #8's Vitamin B12 should have been discontinued on 07/15/25.
-Resident #8's Vitamin B12 level had not been checked since June 2025 because she thought the resident stopped taking it in July 2025.

Based on observations, interviews, and record review, it was determined that Resident #8 was not interviewable.

b. Review of Resident #8's eye care provider order dated 09/22/25 revealed:
-There was a written prescription for Healthy Eyes SuperVision 2 take 1 softgel twice a day with meals. (Healthy Eyes SuperVision 2 is a high-potency eye vitamin with antioxidants and minerals used to support healthy eye function.)
-There was no red "faxed" stamp on the prescription to document the date the order was faxed to the pharmacy.

Observation of the 8:00am medication pass on

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D 358	Continued From page 25 12/03/25 revealed: -The medication aide (MA) prepared and administered morning medications to Resident #8 at 7:34am. -The MA did not prepare and administer a Healthy Eyes SuperVision 2 softgel as ordered on 09/22/25. Review of Resident #8's September 2025 - December 2025 electronic medication administration records (eMARs) revealed there were no entries for Healthy Eyes SuperVision 2 softgels on the eMARs, and none was documented as administered. Observation of Resident #8's medications on hand on 12/03/25 at 10:50am revealed there were no Healthy Eyes SuperVision 2 softgels available for administration. Interview with the MA on 12/03/25 at 10:51am revealed: -She did not administer Healthy Eyes SuperVision 2 to Resident #8 because it was not on the eMAR and there was none available in the medication cart. -She was not aware Resident #8 had an order to receive Healthy Eyes SuperVision 2 softgels. -Resident #8 had not complained to her of any concerns with her eyes or vision. -The Care Coordinators were responsible for sending medication orders to the pharmacy. Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/03/25 at 3:00pm revealed: -The pharmacy staff entered orders into the facility's eMAR system when received. -The pharmacy never received an order for Resident #8's Healthy Eyes SuperVision 2 Eye	D 358		

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D 358	Continued From page 26 Vitamin so they never dispensed any for the resident. -If the pharmacy had received the order for Resident #8's Healthy Eyes SuperVision 2 Eye Vitamin, it would have been scheduled to be administered twice a day at 8:00 and 5:00pm with meals. Interview with the Lead Care Coordinator (LCC) on 12/03/25 at 12:10pm revealed: -The Care Coordinators were responsible for faxing orders to the pharmacy, usually on the same day the order was received. -The red "faxed" stamp was used by the facility to document when an order was faxed to the pharmacy. -Not having a red "faxed" stamp on Resident #8's prescription for the eye vitamin indicated the order was not faxed to the pharmacy. -The pharmacy usually entered orders into the eMAR system, and the Care Coordinators were responsible for reviewing and verifying the orders in the eMAR system. -The Care Coordinators were responsible for following up with the pharmacy if an order was not entered into the eMAR system. -The Care Coordinators should be doing chart audits at least once a month to ensure medications were being administered as ordered. Interview with the Administrator on 12/03/25 at 12:34pm revealed: -The Care Coordinators were responsible for faxing all new medication orders to the pharmacy, except for orders sent to the pharmacy electronically by a provider. -The Care Coordinators were responsible for approving orders in the eMAR system. -The Care Coordinators conducted medication cart audits monthly and chart audits quarterly.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL083007	A. BUILDING: _____ B. WING _____	R-C 12/05/2025

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D 358	Continued From page 27 -She also did random medication checks quarterly. Telephone interview with a patient coordinator at Resident #8's eye care provider's office on 12/03/25 at 2:50pm revealed: -Resident #8 was last seen by the eye care provider on 08/26/25. -Healthy Eyes SuperVision 2 Eye Vitamin was usually prescribed for macular degeneration. (Macular degeneration is a chronic eye disease most often associated with aging and can lead to significant vision impairment.) -Resident #8 should have received Healthy Eyes SuperVision 2 Eye Vitamin when it was prescribed. -Resident #8 should start taking the eye vitamin right away. Telephone interview with Resident #8's eye care provider on 12/03/25 at 4:40pm revealed: -Resident #8's Healthy Eyes SuperVision 2 Eye Vitamin was prescribed for macular degeneration. -There was no immediate concern about Resident #8 not receiving the eye vitamin as ordered but the facility should obtain the eye vitamin and start administering it now. Based on observations, interviews, and record review, it was determined that Resident #8 was not interviewable. 2. Review of Resident #7's current FL-2 dated 12/30/24 revealed: -Diagnoses included dementia, seasonal allergies, major depressive disorder, anxiety, hypertension, and osteoarthritis. -There was an order for Flonase Nasal Spray 50mcg 1 spray in each nostril twice a day. (Flonase Nasal Spray is used to treat seasonal	D 358		

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D 358	Continued From page 28 allergy symptoms.) Review of Resident #7's November 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Flonase Nasal Spray 50mcg instill 1 spray into each nostril twice daily, "family provides". -Flonase Nasal Spray was scheduled for administration at 10:00am and 8:00pm. -Flonase Nasal Spray was documented as not being administered on 11/20/25, 11/22/25, 11/24/25, 11/25/25, and 11/26/25 due to being out of stock. Review of Resident #7's December 2025 eMAR dated 12/01/25 - 12/02/25 revealed: -There was an entry for Flonase Nasal Spray 50mg instill 1 spray into each nostril twice daily, "family provides". -Flonase Nasal Spray was scheduled for administration at 10:00am and 8:00pm. -Flonase Nasal Spray was documented as not being administered on 12/01/25 due to being out of stock and not administered on 12/02/25 due to the resident refusing. Observation of Resident #7's medications on hand on 12/05/25 at 9:54am revealed there was no Flonase Nasal Spray available for administration. Interview with a medication aide (MA) on 12/05/25 at 9:54am revealed: -Resident #7's Flonase Nasal Spray was out of stock. -Resident #7's family member usually provided Flonase Nasal Spray for the resident. -She was not sure if anyone had contacted Resident #7's family member about needing	D 358		

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D 358	Continued From page 29 Flonase Nasal Spray. Telephone interview with Resident #7's family member on 12/05/25 at 11:45am revealed: -She usually brought Resident #7's medications to the facility. -A lot of times, the MAs let her know Resident #7 needed medications after the resident had already completely run out of medication. -Someone at the facility just called her today, 12/05/25, to let her know Resident #7 needed some Flonase Nasal Spray. -She was not told that the resident was completely out of Flonase Nasal Spray, just that the resident needed some. Interview with the Special Care Coordinator (SCC) on 12/05/25 at 4:31pm revealed: -Resident #7's family member bought over-the-counter (OTC) medications for the resident and brought them to the facility, including Flonase Nasal Spray. -The MAs were responsible for notifying Resident #7's family member when the resident's medications were getting low and needed to be brought to the facility. -Resident #7's family member came to the facility every day so the MAs could either let the family member know in person or they could call her on the phone. -The MAs could also let her know when Resident #7's medication supply was running low and she could contact the family member. -She was not aware Resident #7 was out of Flonase Nasal Spray. -Resident #7 had not been having any current allergy symptoms such as sneezing or runny nose. Interview with the Administrator on 12/05/25 at	D 358		

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D 358	Continued From page 30 4:48pm revealed: -She was not aware Resident #7 had run out of Flonase Nasal Spray. -The MAs should notify Resident #7's family member when there was a one-week supply of medication remaining. Attempted telephone interview with Resident #7's primary care provider (PCP) on 12/05/25 at 4:16pm was unsuccessful. Based on observations, interviews, and record review, it was determined that Resident #7 was not interviewable.	D 358		