STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345520	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Gardens Center for Nursing and Rehabilitation	**1028 Blair Street , Thomasville, North Carolina, 27360**

(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) COMPLETION DATE
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 9/22/25 through 09/25/25. An additional intake was received and a survey team returned to the facility to investigate the additional allegations on 10/14/25 and exited on 10/14/25. Due to the government shutdown, the exit date of the survey was adjusted to the date the statement of deficiencies was posted. Therefore, the exit date was changed to 11/14/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 1D7200-H1. In accordance with QSO-26-01-All, the posting of this Statement of Deficiencies was delayed as a result of the Federal Government shutdown. The exit date of this survey has been adjusted based on CMS guidance.	E0000		11/19/2025
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 09/22/25 through 09/25/25. An additional intake was received and a survey team returned to the facility to investigate the additional allegations on 10/14/25 and exited on 10/14/25. Due to the government shutdown, the exit date of the survey was adjusted to the date the statement of deficiencies was posted. Therefore, the exit date was changed to 11/14/25. Event ID#1D7200-H1. The following intakes were investigated: 2621965, 2637197, 2615424, 2609396, 2607364, 2618135, 2599824, 2568618, 778538, 778489, 778534, 778533, 778531, 778529, 778527, 778522, 778520, 778517, 778512, 778524, and 778540. 48 of the 48 complaint allegations did not result in deficiency. In accordance with QSO-26-01-All, the posting of this Statement of Deficiencies was delayed as a result of the Federal Government shutdown. The exit date of this survey has been adjusted based on CMS guidance.	F0000		11/19/2025
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F0657	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:	11/24/2025

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 reverse for further 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

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F0657 SS = D	Continued from page 1 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews and staff interviews, the facility failed to revise the care plan for 1 of 2 sampled residents reviewed for advance directive status (Resident #46). The findings included: Resident #46 was admitted to the facility on 1/10/24 with diagnoses which included: other sequelae of cerebrovascular disease and malignant neoplasm of urinary organ. The resident's portable medical form in the Advance Directive notebook, maintained at the 100 hall nurses' station was reviewed. The Medical Orders for Scope of Treatment (MOST) form with the effective date of 4/4/24	F0657	Continued from page 1 Resident #46 continues to reside in the facility and remains in stable condition. On 9/25/2025 Resident #46's care plan was updated to reflect resident's correct code status. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 9/25/2025 the Director of Nursing (DON)/Assistant Director of Nursing (ADON)/Social Service (SS) completed a review of resident care plans to ensure code status care plans are congruent with code status order and Medical Order for Sustained Treatment (MOST). No concerns identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 9/26/2025 the ADON and DON completed education with SS and Minimum Data Set (MDS) nurse regarding timely updating residents' care plans when the resident's code status changes and ensure order and MOST are congruent. Newly hired SS/MDS will be educated during orientation by the ADON/DON. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The DON or designee will complete an audit two (2) times a week for twelve (12) weeks of resident care plans to ensure resident's code status care plan is updated timely when the resident's code status changes and ensure congruency of code status order, MOST, and care plan. Audit will be any areas of concern will be address by the SS and/or MDS nurse. The DON will present the findings of audit to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three (3) months. The QAPI Committee will review audits to determine trends and/or issues that may need further interventions and/or the need for additional monitoring. Include dates when corrective action will be completed: Compliance Date: 11/24/2025	

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F0657 SS = D	Continued from page 2 documented Resident #46's Advance Directive as Do Not Resuscitate (DNR) with the following interventions: comfort measures; antibiotics if indicated; intravenous fluids for a defined trial period; and no feeding tube. The notebook also consisted of a medical transfer form documenting the resident's Advance Directive status as DNR with the effective date of 9/4/25. The care plan dated 4/27/24 documented Resident #46's Advance Directive status as Full Code (cardiopulmonary resuscitation required). Interventions included: advanced directive wishes to be honored through the review period. Review of the physician's order dated 8/5/24 documented Resident #46's Advance Directive status as DNR. Continued review of Resident # 46's care plan revealed it was not revised with the change in Resident #46's advance directive status as ordered by the physician on 8/5/24. The quarterly Minimum Data Set assessment dated 7/10/25 indicated Resident #46 was cognitively intact. During an interview on 9/24/25 at 11:42 a.m., Unit Manager #1 revealed if a resident was experiencing a medical emergency, the nurse would refer to the 24-report which is updated every shift and included every residents' advance directive status, or the Advance Directive notebook which is maintained at each nurses' station, or the special instructions section of each resident's profile page in the electronic record. Unit Manager #1 stated the advance directive status was also documented in each resident's care plan, but nurses did not routinely refer to the care plan for the advance directive of a resident who was actively in dire medical distress. On 9/25/25 at 11:53 a.m., the Director of Nursing (DON) revealed the MDS Nurse was unavailable for interview. The DON stated Resident #46's care plan should have been revised when the physician's order changed the resident's Advance Directive status from Full Code to DNR. She further stated the MDS Nurse should have updated the resident's care plan as soon as notified of the physician's order change.	F0657		
F0727 SS = F	RN 8 Hrs/7 days/Wk, Full Time DON	F0727	Address how corrective action will be accomplished for	11/24/2025

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F0727 SS = F	Continued from page 3 CFR(s): 1919(b)(4)(C);1919(b)(4)(C)(i);1819(b)(4)(C);1819(Social Security Act §1919 [42 U.S.C. 1396r] §1919(b)(4)(C) Required nursing care; facility waivers.- §1919(b)(4)(C)(i) General requirements.-With respect to nursing facility services provided on or after October 1, 1990, a nursing facility- (II) except as provided in clause (ii), must use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week. Social Security Act §1819 [42 U.S.C. 1395i-3] §1819(b)(4)(C) REQUIRED NURSING CARE.- §1819(b)(4)(C)(i) IN GENERAL.-Except as provided in clause (ii), a skilled nursing facility … must use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week. §483.35(c)(3) Except when waived under paragraph (f) or (g) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(c)(4) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews and staff interviews, the facility failed to provide Registered Nurse (RN) coverage at least 8 consecutive hours per day, 7 days per week for 13 out of 36 days reviewed for staffing (4/27/25, 5/4/25, 5/25/25, 6/1/25, 6/15/25, 6/22/25, 8/23/25, 8/31/25, 9/6/25, 9/7/25, 9/14/25, 9/20/25, and 9/21/25). The findings included: Review of the staffing data submitted by the facility through the CMS (Centers for Medicare and Medicaid Services) Payroll-Based Journal (PBJ) system for	F0727	Continued from page 3 those residents found to have been affected by the deficient practice: The facility failed to have 8 hours of RN coverage 7 days a week. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 9/25/2025 education was provided to Director of Nursing (DON), Assistant Director of Nursing (ADON) and Scheduler that it is required to have eight (8) hours RN coverage seven (7) days a week by the Administrator. Newly hired schedulers will receive education during orientation from the Administrator. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The DON or designee will complete an audit two (2) times a week for twelve (12) weeks to confirm 8 hours of RN coverage. The DON will present the findings of audit to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three (3) months. The QAPI Committee will review audits to determine trends and/or issues that may need further interventions and/or the need for additional monitoring Dates when corrective action will be completed Compliance Date: 11/24/2025	

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F0727 SS = F	Continued from page 4 quarter 3 (April 1, 2025, through June 30, 2025) indicated there was no RN coverage for eight consecutive hours on 4/27/25, 5/4/25, 5/25/25, 6/1/25, 6/15/25, and 6/22/25. Review of the facility's nurse staffing sheets for 8/19/25 through 9/29/25, revealed there was no RN coverage for eight consecutive hours on 8/23/25, 8/31/25, 9/6/25, 9/7/25, 9/14/25, 9/20/25, and 9/21/25. During an interview with the Scheduling Coordinator on 9/25/25 at 2:29 PM, she stated she had been in her role at the facility for 2 weeks. The Scheduling Coordinator could not provide a reason why there was no RN coverage for the listed dates and stated that September's schedule was already completed before she started working. She stated she was aware of the regulation stating there needed to be RN coverage for at least 8 hours in a 24-hour period. The Scheduling Coordinator stated the facility had trouble hiring registered nurses. During an interview with the Director of Nursing (DON) on 9/25/25 at 2:45 PM, she stated the PBJ report and the September days with no RN on the schedule were correct. The DON explained the facility had been without a Staffing Coordinator for several months and the DON completed the nursing schedule. The DON stated they had trouble hiring registered nurses and the facility currently doesn't use any staffing agencies. She reported the facility currently had a pool of 8 to 15 RNs; some full-time and some part-time, and it was difficult to find weekend coverage. The DON reported they were actively trying to hire more registered nurses for weekend shifts. During an interview with the Administrator on 9/25/25 at 3:29 PM, he stated he was not aware the facility was not meeting the federal regulation for RN hours. He stated the facility did not use agency staff and was in the process of trying to hire more registered nurses.	F0727		
F0849 SS = D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices.	F0849	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #3 continues to reside in the facility and remains in stable condition. Resident #3's Medical Doctor's order for hospice services was added on 9/23/2025. Address how the facility will identify other residents having the potential to be affected by the same	11/24/2025

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F0849 SS = D	Continued from page 5 (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death.	F0849	Continued from page 5 deficient practice: On 9/25/2025 the DON completed an audit of residents on hospice services had an active Medical Doctor's order for hospice services. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 9/25/2025 the DON educated the Unit managers, Social Services Director, and Assistant Director of Nursing (ADON) that all residents on hospice services must have an Medical Doctor order for hospice services. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The DON or designee will complete an audit two (2) times a week for twelve (12) weeks of residents on hospice services to ensure residents have a Medical Doctor's order for hospice services. The DON will present the findings of audit to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three (3) months. The QAPI Committee will review audits to determine trends and/or issues that may need further interventions and/or the need for additional monitoring. Date when corrective action will be completed: Compliance Date: 11/24/2025	

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F0849 SS = D	Continued from page 6 (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the	F0849		

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F0849 SS = D	Continued from page 7 resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.	F0849		

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F0849 SS = D	Continued from page 8 §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to ensure a resident had a physician's order to receive hospice services for 1 of 1 resident reviewed for hospice (Resident #3). Findings included: Resident #3 was admitted to the facility on 5/21/25 with diagnoses of stroke with right sided hemiplegia and hemiparesis (paralysis and weakness respectively), vascular dementia and adult failure to thrive. Review of records revealed hospice nurse progress notes which indicated Resident #3 was admitted to hospice on 7/3/25 and was receiving regular hospice orders, care and services. A significant change Minimum Data Set (MDS) assessment on 7/14/25 indicated that Resident #3 was severely cognitively impaired and was coded for hospice services. Further review of Resident #3's medical record revealed no physician order for hospice services. On 9/23/25 at 1:10 PM an interview with Unit Manager #1 was conducted. Unit Manager #1 said hospice orders should be placed in the electronic medical record for a resident by the ordering provider. Unit Manager #1 said there was a binder which at times contained orders from hospice but the binders did not contain the actual Medical Director's order for hospice. An interview with the Director of Nursing (DON) was conducted on 9/23/25 2:11 PM. The DON said when staff received a hospice referral or recommendation, staff called the hospice provider to let them know about the referral, then staff reached out to the physician or nurse practitioner to obtain an actual order if they did not already have one, which could be obtained over the phone. The DON said sometimes a written order could be kept in a hospice binder at the nurses' station but otherwise the order should be entered into the	F0849		

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F0849 SS = D	Continued from page 9 electronic medical record. The DON confirmed there was no written order in the hospice binder for Resident #3 and confirmed there was no hospice order placed in the electronic medical record. In an interview with the Administrator on 9/24/25 at 9:45 AM, the Administrator said that Residents receiving hospice care should have an order placed in the electronic medical record.	F0849		