DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 345520 Y1	MULTIPLE CONSTRUCTION A. Building B. Wing Y2	DATE OF REVISIT 9/18/2023 Y3

NAME OF FACILITY MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 1028 BLAIR STREET THOMASVILLE, NC 27360

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0558 Reg. # 483.10(e)(3) LSC	Correction Completed 08/17/2023	ID Prefix F0582 Reg. # 483.10(g)(17)(18)(i)-(v) LSC	Correction Completed 08/17/2023	ID Prefix F0584 Reg. # 483.10(i)(1)-(7) LSC	Correction Completed 08/17/2023
ID Prefix F0637 Reg. # 483.20(b)(2)(ii) LSC	Correction Completed 08/17/2023	ID Prefix F0656 Reg. # 483.21(b)(1)(3) LSC	Correction Completed 08/17/2023	ID Prefix F0690 Reg. # 483.25(e)(1)-(3) LSC	Correction Completed 08/17/2023
ID Prefix F0808 Reg. # 483.60(e)(1)(2) LSC	Correction Completed 08/17/2023	ID Prefix F0867 Reg. # 483.75(c)(d)(e)(g)(2)(i)(ii) LSC	Correction Completed 08/17/2023	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 7/20/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO