STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345219	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Lane Nursing and Rehabilitation Center	**107 Magnolia Drive , Morganton, North Carolina, 28655**

(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
F0000	INITIAL COMMENTS A complaint investigation survey was conducted from 09/03/2025 through 09/04/2025 Event ID#1D5E23-H1. The following intake was investigated 2598316. 1 of the 2 complaint allegations resulted in deficiency.	F0000		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is	F0755	Magnolia Lane F755 Pharmacy Services/Procedures/Pharmacist/Records On 9/3/25, the facility failed to have effective systems in place for acquiring and maintaining the supply of medications in the controlled medication emergency kit which resulted in an as needed pain medication not being available for Resident #1 when he was admitted to the facility. This deficient practice occurred for 1 of 3 residents reviewed for pharmacy services. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 8/20/25, Hydromorphone 2 mg was received at the facility and placed on the cart for Resident #1. Oxycodone 5mg was received on 8/20/25 at the facility and placed on the cart for Resident #1. On 8/19/25, the Director of Nursing sent the DEA (Drug Enforcement Agency) 222 form to the pharmacy for the restocking of controlled medications for the E-Kit (Emergency Kit). The medications were received on 8/21/25 and restocked into the facility E-kit (Emergency Kit). Address how the facility will identify other residents having the potential to be affected by the same deficient practice:	09/30/2025

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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F0755 SS = D	Continued from page 1 maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with resident, staff, Medical Director (MD) and Pharmacy staff, the facility failed to have effective systems in place for acquiring and maintaining the supply of medications in the controlled medication emergency kit which resulted in an as needed pain medication not being available for Resident #1 when he was admitted to the facility. This deficient practice occurred for 1 of 3 residents reviewed for pharmacy services (Resident #1). The findings included: Resident #1 was admitted to the facility on 8/19/2025 with diagnoses that included aftercare following joint replacement surgery, hypertension, type 2 diabetes mellitus. Resident #1 went to the emergency room within 24 hours of admission, returned to the facility, and discharged to the hospital on 9/1/2025. During a telephone interview on 9/3/2025 at 1:52 PM Resident #1 stated he arrived at the facility late in the evening on the day he was admitted and was told he would not get any medication for at least 12 hours. Resident #1 stated he rang the call light and staff responded, but his medication was not available. Resident #1 stated he knew they gave him something at the facility, but it wasn't the pain medication that helped, so he called 911 to go to the hospital to get his pain medicine. The physician's orders dated 8/19/2025 revealed Resident #1 had the following orders: · Oxycodone HCL 5 milligrams (mg) give one tablet by mouth every 4 hours as needed for pain scale 4-6 for 7 days · Tramadol HCL 50 mg give one tablet by mouth every 8 hours as needed for pain scale 1-3 for 14 days. · Acetaminophen 325 mg give two tablets by mouth every 4 hours as needed for pain · Hydromorphone HCL 2mg give 0.5 (half) tablet by mouth every 6 hours as needed for pain for 7 days Review of Resident #1's hospital discharge summary revealed the facility physician's orders were accurately transcribed from the discharge summary.	F0755	Continued from page 1 The facility Administrator will ensure that this plan of correction is initiated and followed as it is written. On 9/4/25, the Director of Nursing and the Assistant Director of Nursing completed a 100% audit of the facility E-Kits (Emergency Kits) and 100% audit all residents with controlled medications to ensure medications were available for resident use. No medications were unavailable. Medications that were low in stock were ordered from the pharmacy as appropriate. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 9/5/25, the Director of Nursing and the Assistant Director of Nursing began in-service education with 100% of all licensed nurses and medication aides to include contract and agency staff on the following: the process for notifying the Director of Nursing when a medication is used from the E-Kit (Emergency Kit), ensuring residents have all ordered controlled medications available in the medication cart for use, and the process of ordering and re-ordering controlled substance medications for residents. The process for notifying the Director of Nursing and the Assistant Director of Nursing that a medication has been used from the E-Kit (Emergency Kit) or that the Kit is low in stock is to fill out the E-Kit (Emergency Kit) form and place in her box. This education was completed on 9/6/25. Any licensed nurse and medication aide to include contract and agency staff who has not received the education by 9/6/25, will receive prior to their next scheduled shift. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing/Assistant Director of Nursing will audit 5 residents-controlled substances, once per week for 4 weeks to ensure all residents have their controlled substances available for use per order. Any controlled medications that are low in stock or unavailable will be re-ordered immediately and the provider notified as appropriate. All areas of concern will be taken to the administrator and the Director of Nursing and addressed immediately, including re-education of nurses or medication aides to include contract and agency staff as appropriate.	

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F0755 SS = D	Continued from page 2 The physician's order dated 8/20/2025 revealed Resident #1 had the following orders: · Tramadol 50mg HCL give 50mg by mouth one time only for pain for one day The August 2025 Medication Administration Record (MAR) revealed Resident #1 received: · Tramadol HCL 50mg on 8/19/2025 at 11:15 PM · Acetaminophen 650mg on 8/20/2025 at 2:05 AM. · Tramadol HCL 50mg on 8/20/2025 at 2:30 AM. · Hydromorphone 1mg on 8/20/2025 at 10:52 AM · Hydromorphone 1mg on 8/20/2025 at 5:48 PM. Review of Resident #1's electronic medical record revealed an admission pain assessment was completed on 8/20/2025 at 1:27 AM, indicated Resident #1 had a pain level of 8, described as aching/penetrating to the right knee. The assessment also revealed Resident #1 had an as needed (PRN) medication ordered and it was effective in relieving pain. Review of a progress note written by Nurse #1 revealed Resident #1 arrived at the facility just prior to the start of her shift. Resident #1 rang requesting pain medication, and Nurse #1 explained the orders had to be verified by the doctor and entered into the system and not all of the medications would be available right away, which included the hydromorphone and oxycodone. Resident #1 was upset that all his medications were not all available. Nurse #1 administered Tylenol and Tramadol as ordered. Nurse #1 made several rounds on Resident #1 after the PRN pain medications were administered and Resident #1 was sleeping. Resident #1 rang for pain medication at 2:05 AM, Nurse #1 contacted the on-call Nurse Practitioner and received an order for a one-time dose of Tramadol HCL 50mg. Resident #1 yelled at Nurse #1 that he wanted to leave because the facility did not have his medications and were not prepared to take care of him. Nurse #1 prepared to call the hospital and was informed by Nurse #2 that Resident #1 had called 911 on his own. Nurse #1 called Emergency Medical Services (EMS) and the local hospital, gave report on Resident #1, the Director of Nursing (DON), on-call NP were notified, and Resident #1 was transported by EMS to a local hospital. During a telephone interview on 9/3/2025 at 5:17 PM Nurse #1 stated she worked a twelve-hour shift that	F0755	Continued from page 2 The Director of Nursing/Assistant Director of Nursing will audit the E-Kit (Emergency Kit) 2x weekly for 4 weeks to ensure an adequate supply is maintained and available for emergency use in providing pain management for resident care. Any concerns or need to re-order will be addressed immediately by the Director of Nursing and pharmacy notified as appropriate to ensure the E-Kit (Emergency Kit) is re-stocked. The Director of Nursing/Administrator or Director of Nursing will present the findings of the Audit Tools to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 2 months. The QAPI Committee will meet monthly for 2 months and review the Audit Tools to determine trends and/or issues that may need further interventions and the need for additional monitoring. Date of Compliance: 9/30/25	

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F0755 SS = D	Continued from page 3 started at 7:00 PM on 8/19/2025, when she arrived for her shift at approximately 6:45 PM the ambulance that had transported Resident #1 to the facility was still in the parking lot. Nurse #1 stated some hard scripts for pain medication had arrived with Resident #1 when he was admitted on 8/19/2025, she thought it was for Tramadol and Hydromorphone, and possibly oxycodone, but she didn't remember specifically. Nurse #1 stated when she first assessed Resident #1, he did not complain of pain. Nurse #1 stated when Resident #1 complained of pain, Nurse #2 assisted Nurse #1 by entering Resident #1's orders, and acetaminophen and tramadol HCL were administered to Resident #1, since hydromorphone was not a stocked medication, and oxycodone was out in the controlled medication emergency kit. Nurse #1 stated Resident #1 was upset that all his medications were not available and Nurse #1 explained, they did not have the hard scripts and orders until Resident #1 arrived, and if the administered pain medication did not work Nurse #1 would call the on-call provider. Nurse #1 stated Resident #1 then went to sleep for a few hours and woke up and complained of pain again. Nurse #1 contacted the on-call provider since there was no oxycodone, and it was not time for another dose of Tramadol. Nurse #1 stated she reported to the NP what pain medications were available in the controlled medication emergency kit, and a one-time order for another Tramadol 50mg was received. Nurse #1 stated when she administered the second dose of Tramadol 50mg, Resident #1 grabbed the medicine cup from her and stated he wanted to go to the hospital. Nurse #1 stated as she prepared to call the hospital, she received a call from Nurse #2 that Resident #1 had called 911 to be taken to the hospital, and the hospital was on the phone to verify if transport was needed. Nurse #1 stated she spoke to the hospital and EMS and Resident #1 was transported to the hospital and did not return during the rest of her shift. Nurse #1 stated she did not recall another time the oxycodone had run out in the controlled medication emergency kit prior to 8/19/2025. Nurse #1 also stated there had been a few admits that same day. Nurse #1 stated she thought orders had to be in to the pharmacy by 4:00 PM in order for new admissions medications to be received that day. Nurse #1 stated Resident #1 had been admitted after the cut-off time for the pharmacy, so the medications that were not in back up would arrive in the delivery the following day. During a telephone interview on 9/3/2025 at 3:18 PM Nurse #2 stated she worked on 8/19/2025 from 7:00 PM to 7:00 AM but was not assigned to Resident #1. Nurse #2 stated she answered a phone call from Resident #1, and he stated he wasn't getting any pain medication. Nurse #2 looked at his electronic record and noted no orders	F0755		

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F0755 SS = D	Continued from page 4 had been entered and went to help Nurse #1. Nurse #2 stated she assisted Nurse #1, entered orders and obtained Tramadol from the controlled medication emergency kit. Nurse #2 stated the controlled medication emergency kit was out of oxycodone and that was not the first time that had happened but did not recall the other dates it had occurred. Unable to interview the Nursing Assistant (NA) assigned to Resident #1 on 8/19/2025. During an interview on 9/3/2025 at 12:14 PM the Medical Director (MD) stated Resident #1 was admitted on 8/19/2025 with 3 different controlled medications for pain and the hydromorphone is the only pain medication that the facility did not stock in the controlled medication emergency kit. The MD stated Resident #1 arrived late in the evening on 8/19/2025 and only arrived with two pieces of paper from the hospital not the full discharge summary. The MD stated the facility was trying to cover Resident #1's pain with the controlled medication emergency kit medications until the hydromorphone was available, but Resident #1 called 911 himself early in the morning on 8/20/2025, was sent to the hospital, received pain medication and was sent right back to the facility. The MD stated the facility normally had oxycodone in the controlled medication emergency kit. The MD stated on 8/20/2025 an emergency order for Hydromorphone was sent to a local pharmacy. During a telephone interview on 9/3/2025 at 12:37 PM Nurse #3 stated she had not worked when Resident #1 was admitted but heard Resident #1 called 911 himself after being admitted. Nurse #3 stated there is a controlled medication emergency kit that contains medications that can be pulled for new orders or new admits. Nurse #3 stated they medications in the controlled medication emergency kit are not ordered consistently and there have been other times when medications that were supposed to be in the kit have run out. Nurse #3 stated she was assigned to Resident #1 a day or two after his admission and all his medications had arrived from the pharmacy. During an interview on 9/3/2025 at 12:45 PM Nurse #4 stated she worked 8/20/2025 from 7:00 AM to 7:00 PM and was assigned to Resident #1. Nurse #4 stated she thought Resident #1 had been admitted late in the evening on 8/19/2025, called 911 himself and was transferred to the hospital then returned from the hospital early during Nurse #4's shift. Nurse #4 stated that if new residents' orders were not sent into the pharmacy before 5:00 PM they would not arrive until the next day.	F0755		

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F0755 SS = D	Continued from page 5 During an interview on 9/3/2025 at 1:15 PM the Admission Coordinator stated Resident #1 did not arrive until almost 7:00 PM on 8/19/2025 due to an issue with transportation. The Admission Coordinator stated she was not involved with the resident's medication orders, they are given to the nurse to verify and be entered into the system. The Admission Coordinator stated she completed paperwork with Resident #1 on the evening of 8/19/2025 and Resident #1 had not voiced any complaints of pain and did not appear to be in any distress. The Admission Coordinator stated she had been told Resident #1 had gone out to the hospital after admission and returned to the facility. The Admission Coordinator stated she checked in on Resident #1 on 8/20/2025, Resident #1 voiced he had some pain, but did not appear to be in distress and did not voice any complaints. During an interview on 9/3/2025 at 3:15 PM the Director of Nursing (DON) stated she checked the controlled emergency medication kit on Mondays and Fridays. The DON stated that when the controlled emergency medication kit needed to be refilled, she faxed the DEA 222 form to the pharmacy so they knew she needed the medication, and the courier would know it needed to be picked up. The DON stated the process had recently changed and now they did not receive the medication on the day she faxed the form; the medication came back a few days later after being processed by the pharmacy. The DON stated she completed the form on 8/18/2025 and faxed it to the pharmacy. The DON stated during the courier exchange on 8/18/2025 the pharmacy courier had left paperwork from the pharmacy tote on the desk, and it had not been taken back to the pharmacy. The DON stated she changed the date on the form to the 19th, because the forms were really expensive, and called the pharmacy to report the papers being left and was told the courier had been fired. The DON stated the medications did not arrive on 8/19/2025 so she refaxed the form and called the pharmacy regarding the medications that needed to be refilled. The DON stated on 8/20/2025 the medication for the emergency kit had still not arrived and she faxed the form again and called the pharmacy and was told she had to send the original form to the pharmacy for it to be filled. The DON provided a copy of the DEA 222 form she had referenced. The date on the DEA 222 form read 8/18/2025 that appeared to have been changed from 8/19/2025. During a telephone interview on 9/3/2025 at 3:59 PM the Pharmacist stated the facility ordered #12 oxycodone 5mg tablets on 6/18/2025 and 8/21/2025. The Pharmacist stated controlled medications for the emergency kit are only dispensed from an original hard copy of the DEA	F0755		

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F0755 SS = D	Continued from page 6 222 form, never filled from a faxed form. The Pharmacist stated she would provide the policy for ordering medications for the controlled medication emergency kit. The Pharmacist stated they filled controlled medication emergency kits per the state guidelines. During a telephone interview on 9/3/2025 at 4:06 PM the Pharmacy Manager stated they did not have a record of a faxed DEA 222 form from the facility from 8/18/2025, 8/19/2025, 8/20/2025. The Pharmacy manager stated they did not refill the controlled medication emergency kit medication from a faxed form. The Pharmacy manager stated if the DON had called and reported there was an emergent need for the controlled medication emergency kit, they would send the medications to be delivered only if the original DEA 222 form was present at the facility for the courier to exchange, otherwise the normal process is the completed DEA 222 form is placed into the medication tote in an envelope labeled that the DEA 222 form in inside, for the courier to pick up, then the next day it is processed in the pharmacy and delivered back to the facility. The Pharmacy Manager provided an emailed copy of the DEA 222 form the pharmacy had received from the facility with a date of 8/19/2025. The form order number matched the copy provided by the DON. Review of the Policy titled: Procedure for the completion of DEA FORM 222 Policy: that was dated June of 2021 revealed under Procedure: 2. If at any time a discrepancy in the entry of data on this DEA Form 222 is made, do not make corrections. Mark the form VOID in large letters, keep the voided form on file, and start over with a new form. The pharmacy cannot accept any form on which corrections or alterations have been made. 3. After completion of the DEA Form 222, the Purchaser (facility staff member) shall make a copy of the Form and send the original Form to Neil Medical Group via Pharmacy Courier. In an emergency, if the existing supply is out or nearly out and a refill supply is needed that evening, one may fax the DEA Form 222 to the pharmacy and place the original in the pharmacy delivery tote in an envelope labeled “Attention Pharmacist”, DEA Form 222”. When the pharmacy courier reaches the facility, he will present a “Pick-Up and Delivery” form guiding him to pick-up the original copy of the DEA Form 222 in exchange for the emergency kit medications.	F0755		

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F0755 SS = D	Continued from page 7 4. Retain the copy of DEA Form 222, fill in quantity of medication received, and date received (Part 5) when the replacement medications are actually received by the facility. Keep this copy on file in the facility for a period of not less than two (2) years. During a follow up interview on 9/4/2025 at 8:34 AM the Pharmacy Manager stated the pharmacy did not require a fax for the controlled medication emergency kit to be refilled, that was not part of the policy. The Pharmacy manager stated there was no record of calls or faxes regarding the controlled medication emergency kit from 8/18/2025 through 8/19/2025. The Pharmacy manager stated she was not aware of any papers that had been left out in a facility by a courier. The Pharmacy Manager stated the process for couriers is to pick up the pharmacy totes and contents at every delivery. If controlled medications are being returned the form must be faxed so the courier can match what is being picked up for verification. The Pharmacy Manager stated the DEA 222 form used to order the controlled medication emergency kit is supposed to be placed in the pharmacy tote for the courier to pick up. The normal process is the courier drops off a new tote and picks up the old tote on every delivery. The Pharmacy Manager stated if the facility had called and told them they were out of medication for the controlled medication emergency kit on 8/19/2025 they could have faxed the form, and the pharmacy would have done an emergency exchange for the original form. The Pharmacy Manager stated they do not have a copy of the inventory of the facility's emergency kit. The Pharmacy Manager stated medications can be ordered for replacement for the controlled medication emergency kit seven days a week. The Pharmacy Manager verified the most recent DEA 222 form received from the facility was dated 8/19/2025 and was received in the pharmacy on 8/21/2025 and filled that day. During a telephone interview on 9/4/2025 with the Vice President of the Pharmacy and the Pharmacy Manager, the Vice President of the Pharmacy stated normally the DEA 222 form is filled out, sealed in an envelope labeled “Attention Pharmacist” and placed in the tote then it could take 24 hours to be processed and filled. The Vice President of the Pharmacy stated the controlled medication emergency kit was an option the facility had and was not required. The Vice President of the Pharmacy stated the root cause of the issue was the late admission and the hospital sending the resident with unusual and multiple medications. The Vice President of the Pharmacy also verified the original DEA 222 form the pharmacy had was dated 8/19/2025.	F0755		

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F0755 SS = D	Continued from page 8 During a follow up interview on 9/4/2025 at 11:26 AM with the DON and Regional Corporate Nurse, the DON stated the pharmacy did not get the forms from the 8/18/2025 when it was left by the courier, so the date was changed, and it was refaxed on the 8/19/2025 and said it was an emergency. The DON verified the copy of the DEA 222 form she had provided looked like the date was changed from a 19 to 18 but stated she did not make that change. The DON stated she had a DEA 222 form with 8/18/2025 on it but was unable to provide the form. The DON was unable to provide the declining count sheet for the oxycodone from the controlled medication emergency kit from June and July of 2025 to show when the oxycodone had run out. The DON stated the completed declining narcotic sheets were normally placed in a binder after they were put in her box, but a new policy started the 3rd week of August, that the completed declining narcotic sheets were put in a black box that the DON could open with a key. The DON stated she was on vacation at the end of July, and the former Administrator and Staff Development Coordinator were supposed to cover and file them for the DON, but those staff members were no longer working at the facility. The DON stated she normally checked the controlled emergency medication kit on Mondays and Fridays but did not have a record of the inventory when it was checked. The DON stated she would just take a piece of paper, look at the declining inventory sheet and order what was needed, or sometimes the nurse on the hall would text her how many were left in the kit. The DON stated ideally the facility would have the medication ordered for the residents. The DON indicated she now knew the specifics of the policy to reorder the controlled medication emergency kit, and she would follow the policy from now on. The DON further stated she had been keeping up with it by herself but had support now. During an interview on 9/4/2025 the Administrator stated he expected the policy to be followed for the reordering of the medications in the controlled medication emergency kit, and he expected the facility to have medications available for the residents.	F0755		