

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(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  Magnolia Lane Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  107 Magnolia Drive Morganton, NC 28655	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.  (continued on next page)

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 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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 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 [DATE] 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 daysReview of Resident #1's hospital discharge summary revealed the facility physician's orders were accurately transcribed from the discharge summary. 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 dayThe 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 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 [DATE], 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</p>		