

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/18/2025
NAME OF PROVIDER OR SUPPLIER  Magnolia Gardens Center for Nursing and Rehabilita		STREET ADDRESS, CITY, STATE, ZIP CODE  1028 Blair Street Thomasville, NC 27360	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review, and interviews with facility staff, resident, and the Contracted Van Transportation Company Owner, the facility failed to ensure Resident #1's wheelchair was secure on the contract transportation van lift by the Contract Van Driver before the lift platform was raised to the elevated position. On 3/7/25, Resident #1 was loaded onto the van lift by the Contract Van Driver. The lift was positioned at the rear entrance of the van and Resident #1 was facing out away from the van. When the lift platform was at the floor level of the van, Resident #1's wheelchair rolled forward, away from the van, and Resident #1 fell forward, off of the lift, landing on the asphalt parking lot. Resident #1 fell approximately 48 inches from the raised lift platform onto the ground. According to the resident, she had tried to put her arms out to catch herself as she was falling. Resident #1 was transported to the hospital via Emergency Medical Services (EMS) and at the hospital, Resident #1 was found to have sustained fractures to both upper arms, multiple lumbar vertebrae (lower back) fractures, and a fracture to her right foot. Resident #1 also sustained a laceration to her right forehead measuring 4 centimeters in length which required 4 sutures to close. Resident #1 was receiving a blood thinner which increased her risk of bleeding. There is a high likelihood of a serious adverse outcome, including death or injury, when the manufacturer's instructions for loading residents onto the transportation van lift are not followed. This deficient practice was found for 1 of 3 residents reviewed for accidents. The findings included: Review of the manufacturer's operating instructions showed the following instructions for the use of the contract transportation van lift to load a resident in a wheelchair. 1. Stand clear and press the unfold switch until the platform stops (reaches floor level of the vehicle - unfold fully). 2. Press the DOWN switch until the entire platform reaches ground level and the roll stop (a piece of metal attached to the lift which unfolds to a flat position when the lift is on the ground but is in an upright position when the lift is not in contact with the ground) unfolds fully (ramp position). 3. Load passenger onto platform, lock wheelchair brakes, and buckle handrail belt (if equipped). Ensure passenger is fully positioned inside the yellow boundaries. 4. Press UP switch and raise platform to floor level; approximately 48 inches from ground level to floor of van per lift manual specifications. 5. Unlock wheelchair brakes and unload passenger from platform and move into the van. Resident #1 was admitted to the facility on [DATE] with diagnoses included polyneuropathy (numbness and weakness in extremities), severe obesity, and a history of deep venous thrombosis. Resident #1's quarterly Minimum Data Assessment (MDS), dated [DATE], coded the resident as having no cognitive impairment. The resident was coded to use a wheelchair for ambulation and was dependent on staff for all activities of daily living except Resident #1 was independent with eating and oral hygiene. The MDS showed Resident #1 weighed 415 pounds. Review of the physician orders showed Resident #1 had an active order last reviewed and dated for 1/5/25 for apixaban (a blood thinner) 2.5 milligrams, take one tablet twice daily. Review of the February and March 2025 Medication Administration Record showed Resident #1 was administered the apixaban twice daily including a dose on the morning of 3/7/25. There had been no documented dose omissions from 2/1/25 to 3/7/25. Review of a statement provided to the facility by the Contract Van Driver dated 3/7/25 read in part, I loaded the resident on the lift facing outward due to her size and the size of the wheelchair. The lift is appropriate for facing outward loading. After loading her on the lift I locked the brakes and checked them, then raised the lift to the van floor level. The statement continued to document the driver walked around to the right side of the van to enter via the side passenger doorway. As the Contract Van Driver was walking up the steps, he noticed her (Resident #1's) chair began to roll forward toward the outside of the van. Contract Van Driver had documented he immediately moved toward her, but her chair hit the roll stop. Her momentum carried her and her wheelchair over the end of the lift where she landed on the pavement and her chair was resting on top of her. The Contract Van Driver documented he removed the wheelchair without moving the resident and at that time two unknown people arrived at her side. Contract Van Driver was unavailable for interview. An interview was conducted with Resident #1 on 7/17/25 at 10:20 AM. Resident #1 stated she was leaving the facility in a wheelchair for an appointment right after lunch on 3/7/25. Resident #1 stated the Contract Van Driver pushed her to the end of the sidewalk of the main facility entrance and loaded her onto the van lift at the back of the van. Resident #1 stated she was in a large wheelchair and felt like it took up the entire platform. Resident #1 stated she was facing the parking lot when the Contract Van Driver began to raise the lift. Resident #1 reported she felt like the wheelchair was stable on the platform but wasn't sure if</p>		