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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Gardens Center for Nursing and Rehabilita	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)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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 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 [DATE] 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.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 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 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.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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 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.