STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey with a complaint investigation from 04/22/25 to 04/25/25 and 04/28/25 to 04/29/25. The complaint investigation was initiated by the Warren County Department of Social Services on 03/11/25.	D 000		
D 067	10A NCAC 13F .0305 (h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) in facilities with at least one resident who is determined by a physician or is otherwise observed by staff to be disoriented or exhibits wandering behavior, a continuously sounding device that is activated when the door is opened shall be located on each exit door that opens to the outside. The sound shall be audible in the facility. If a central system of remote sounding devices is provided, the control panel shall be powered by the facility's electrical system, and be in a location accessible by staff to operate the control panel. Notwithstanding the requirements of Rule .0301, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 3 exit doors in the Assisted Living (AL), had engaged audible alarms allowing residents to exit the	D 067		

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D 067	Continued From page 1	D 067		

facility without staff's knowledge, including two residents who were intermittently disoriented and resided in the AL (#5, #12); and 1 of 1 exit doors in the Special Care Unit (SCU) which was propped open, disengaging the alarm, allowing a resident, who was constantly disoriented to exit the facility without staff's knowledge.(#16).

The findings are:

Review of Resident #5's current FL-2 dated 12/31/24 revealed:
-Diagnoses included schizophrenia, hypertension, and constipation.
-The resident's information was blank; there was no orientation status checked.

Review of Resident #5's care plan dated 12/31/24 revealed:
-He was disoriented sometimes.
-He was forgetful and needed reminders.

1. Observation of the exit door at the end of the A-hall on 04/22/25 at various times between 8:30am and 4:00pm revealed:
-The exit door at the end of the A-hall led outside to the smoking area.
-There was a red alarm box on the wall next to the door.
-There was a pin inserted into the alarm box connected to a cable which was looped on the opposite end.
-The cable loop was not over the door handle.
-Residents were entering and exiting the door to smoke.
-There was no audible sound when the residents entered or exited the door.
-There were no staff supervising residents who came in and out the door.

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D 067	Continued From page 2 Observation of the exit door at the end of the AL A-hall on 04/23/25 at various times between 11:00am and 3:30pm revealed: -The cable that would activate the alarm was not attached to the door handle. -There were no staff supervising residents who came in and out the door. Observation of the exit door at the end of the A-hall on 04/24/25 at various times between 10:00am and 2:30pm revealed: -The cable that would activate the alarm was not attached to the door handle. -There were no staff supervising residents who came in and out the door. Observation of the exit door at the end of the A-hall on 04/28/25 at 8:05am revealed: -The exit door leading to the smoking area was not alarmed; the cable was not connected to the door handle. -There were no staff supervising residents who came in and out the door. Interview with a medication aide (MA) on 04/24/25 at 1:11pm revealed she knew the exit door at the end of the A-hall did not alarm because the residents went in and out all day to smoke. Interview with a second MA on 04/25/25 at 11:02am revealed: -The exit door at the end of the A-hall was not alarmed during the day so the residents who smoked could go outside and smoke. -The second shift staff alarmed the door at 9:00pm. -A couple of residents would go out after 9:00pm to smoke and the door would alarm.	D 067		

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D 067	Continued From page 3 Interview with the Maintenance Director on 04/24/25 at 3:03pm revealed: -The cable attached to the red box should be connected to the door handle. -When the door was opened the cable would detach from the red box and the alarm would sound. -The cable could be removed from the door handle and when the door was opened there would be no audible alarm. -Some of the residents could remove the cable from the door handle and open and exit the door without the alarm sounding. -He could name four residents that he had seen remove the cable from the door handle and go out of the facility to the smoking area. -The exit door leading to the smoking area was not alarmed during the day so residents could go outside and smoke. -The exit door was alarmed from 9:00pm to 7:00am. Interview with the RCC on 04/28/25 at 2:46pm revealed: -There were red box alarms next to the exit door. -There was a cable connected to the red alarm box and to the handle on the exit door. -When the door was opened, it would pull the cable out of the red alarm box, causing the alarm to sound. -If the cable had been removed from the door handle, then the door would not alarm when opened. -The exit door leading to the smoking area was not alarmed during the day so the residents could go in and out of the door to smoke. -The alarm to the exit door was alarmed at 7:00pm. Interview with the Administrator on 04/29/25 at	D 067		

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D 067	Continued From page 4 4:24pm revealed: -The exit door leading to the smoking area was not alarmed during the day -Residents were in and out of the door to the smoking area frequently throughout the day. -The exit door to the smoking area would be locked and the alarm placed on the door each night. Interview with a resident on 04/28/25 at 4:10pm revealed: -The exit door to the smoking area was not alarmed during the day. -The staff placed the alarm on the door around 9:00pm each night and removed the alarm around 7:00am. -He had heard the exit door alarm go off several mornings between 5:00am and 6:00am, but he did not know why the alarm went off. -He knew of a resident who walked away from the facility about 3 months ago. -The staff realized he was missing and went looking for him; he did not know how long the resident had been missing. -He was told by staff that the resident was located down the road about ½ mile. Interview with a personal care aide (PCA) on 04/29/25 at 9:32am revealed: -The exit door to the smoking area was not alarmed on first shift. -The residents who smoked would go in and out of the door during the shift. Interview with the Administrator on 04/29/25 at 4:24pm revealed: -The smoking area had a fence around it so the residents could not "get out" and into the parking lot. -The fence had a gate that she had seen opened	D 067		

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D 067	Continued From page 5 some mornings when she arrived at work. -The gate on the fence had a latch on it, but it could not be locked. Refer to the interview with the Maintenance Director on 04/24/25 at 3:03pm. Refer to the interview with the Administrator on 04/24/25 at 4:06pm. Refer to the interview with the Regional Director on 04/28/25 at 8:17am. 2. Observations of the exit door in the television room on the A-hall on 04/22/25 between 9:14am and 12:28pm revealed: -The exit door led to the front of the facility and the parking lot. -There was a red alarm box on the wall next to the door. -There was a pin inserted into the alarm box connected to a cable which was looped on the opposite end. -The cable loop was not over the door handle. -There were no staff supervising residents Observation of the exit door in the television room on 04/23/25 at various times between 1:00pm and 3:56pm revealed: -The door was not alarmed. -There were no staff supervising residents in the area of the door. Observation of the television room on 04/24/25 at 12:28pm revealed: -The exit door was not alarmed. -There were no staff supervising residents in the area of the door.	D 067		

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D 067	Continued From page 6 Observation of the television room on 04/28/25 at 8:03am revealed: -The exit door was not alarmed; the cable was not connected to the door handle. -There were no staff supervising residents in the area of the door. Interview with the Maintenance Director on 04/24/25 at 3:03pm revealed: -The cable attached to the red box should be connected to the door handle. -When the door was opened the cable would detach from the red box and the alarm would sound. -The cable could be removed from the door handle and when the door was opened, the door would not be alarmed. Interview with the RCC on 04/28/25 at 2:46pm revealed: -There were red box alarms next to the exit doors, except the front door. -There was a cable connected to the red alarm box and to the handle on the exit door. -When the door was opened, it would pull the cable out of the red alarm box, causing the alarm to sound. -If the cable had been removed from the door handle, then the door would not alarm when opened. -She did not know the exit door in the television room on A-hall was not alarmed. -She did not know how the cable was removed from the exit door. -She had never seen a resident remove an alarm cable from a door handle. Interview with the Administrator on 04/29/25 at 4:24pm revealed: -The exit door in the television room should be	D 067		

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	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 067	Continued From page 7	D 067		

alarmed with a cable from the red box to the door handle.
-She had not seen the exit door in the television room disengaged.

Refer to the interview with the Maintenance Director on 04/24/25 at 3:03pm.

Refer to the interview with the Administrator on 04/24/25 at 4:06pm.

Refer to the interview with the Regional Director on 04/28/25 at 8:17am.

3. Observation of the front door on 04/22/25 at 5:00pm revealed the front door did not alarm when exiting the facility, but it did alarm when entering that morning, 04/22/25.

Observation of the front door on 04/23/25 at various times between 7:45am and 6:05pm revealed:
-At 7:45am, the front door did not alarm when opened.
-At 2:00pm, the front door was not latched, and there was no audible alarm heard when re-entering the facility.
-At 6:05pm, the front door was propped open with a chair when leaving the building and there was no audible alarm heard.
-There were no staff supervising residents in the area of the door.

Observation of the front door on 04/24/25 at 10:15am revealed the front door did not alarm when exiting the facility.

Observation of the front door on 04/25/25 at various times between 12:45pm and 4:15pm revealed:

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	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 067	Continued From page 8 -At 12:45pm, the front door did not alarm when exiting the facility. -At 2:20pm, the front door was not latched and there was no audible alarm upon re-entry into the facility. -There were 2 residents sitting outside and 3 residents sitting in the common area unsupervised. -At 3:30pm, the front door was not latched. -At 4:15pm, a resident opened the front door, reached on top of the door and disengaged the lock so the door would not close. Observation of the front door on 04/28/25 at 8:00am revealed the front door was not latched and there was no audible alarm. Interview with a second resident's family member on 04/28/25 at 9:06am revealed: -The front door was unlocked most of the time when she visited the facility. -She did not recall hearing an alarm when she opened the front door. Interview with a resident on 04/25/25 at 4:15pm revealed: -He would pop the button on top of the door to release something so the door would not close and lock. -He would be going back into the facility shortly and he did not want to have wait on anyone to open the door for him. Interview with a second resident on 04/28/25 at 6:17pm revealed: -He disconnected the alarm on the front door when he went outside by reaching on top of the door and clicking a button. -When he disconnected the alarm, the door would not shut completely, and he could get back	D 067		

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D 067	Continued From page 9 into the facility without ringing the doorbell. Interview with a MA on 04/24/25 at 1:11pm revealed the alarm on the front door could be by-passed, unless a new system had been installed. Interview with the Maintenance Director on 04/25/25 at 3:30pm revealed: -The front door was not latched because someone entered or exited the facility and did not pull the door closed. -The door should automatically close and latch, but sometimes the door did not latch. -The person entering or exiting was responsible for making sure the door was closed and latched. Interview with the RCC on 04/28/25 at 2:46pm revealed: -The front door was always alarmed. -She did not know the front door was propped open at times disengaging the alarm. Interview with the Administrator on 04/29/25 at 4:24pm revealed: -The front door was closed and locked from the outside; it made a chirping sound when the door was opened. -The front door did not latch at times, causing the alarm to not sound when the door was opened. -She did not know how the resident reached the top of the door and unlatched it so it would stay open with no audible alarm. -She had the Maintenance Director work on the front door last week because it was not latching, which caused the front door not to close completely. -She did not know the front door was still being found unlatched with no alarm.	D 067		

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D 067	Continued From page 10	D 067		

Review of Resident #12's current FL-2 dated 06/26/24 revealed:
-Diagnoses included major neurocognitive disorder and trauma.
-He was intermittently confused.
-He was ambulatory.

Review of Resident #12's care plan dated 07/22/24 revealed:
-He was oriented.
-He had an alcohol disorder.

Review of Resident #12's incident/accident report dated 03/03/25 revealed:
-There was no time documented.
-The incident/accident occurred on second shift.
-He walked outside of the gate and down the road.

Interview with Resident #12 on 04/24/25 at 3:30pm revealed:
-He walked out of the front door and out of the front entrance/exit gates of the facility on 03/03/25.
-He wanted to go to the store and buy some cigarettes.
-He walked down the road toward town.
-When he got to the top of the hill, he turned around and came back to the facility because it was getting dark.
-He had left the facility several times and the staff did not know.
-The staff had come looking for him on two different occasions when he had left the facility.

Interview with a PCA on 04/29/25 at 9:32am revealed Resident #12 would go outside without supervision to smoke.

Interview with a medication aide (MA) on

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D 067	Continued From page 11 04/24/25 at 1:11pm revealed: -Resident #12 talked about walking away from the facility to purchase cigarettes. -Resident #12 walked away one day and he was picked up on the side of the road by staff. -Resident #12 said he was going to get cigarettes. Interview with the RCC on 04/28/25 at 2:46pm revealed: -Resident #12 left the facility through the exit door at the end of the A-hall which led to the smoking area. -The smoking area was enclosed with a fence but the gate on the fence was not secured. -Resident #12 walked out the front gate when a car was entering or leaving. -Resident #12 was picked up walking down the road toward town. -Resident #12 got in her car and she brought him back to the facility on 03/03/25. -Resident #12 did not leave the facility when the front gate was broken and would not close; he left when the front gate was working and he either left when a car entered or a car exited. -Resident #12 did not usually leave the facility. -She did not know that he left the facility more than once. Interview with the Administrator on 04/24/25 at 4:06pm revealed: -When she started working at the facility, about two months ago, Resident #12 would walk to the store to buy cigarettes. -She started buying his cigarettes so he would not have to leave the facility. -He still left the facility. Refer to the interview with the Maintenance Director on 04/24/25 at 3:03pm.	D 067		

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D 067	Continued From page 12 Refer to the interview with the Administrator on 04/24/25 at 4:06pm. Refer to the interview with the Regional Director on 04/28/25 at 8:17am. 4. Review of Resident #16's current FL-2 dated 02/04/25 revealed: -Diagnoses included dementia, major depressive disorder, and generalized anxiety disorder. -His level of care was special care unit (SCU). -He was constantly disoriented. -He wandered. -He was ambulatory and non-verbal. Review of Resident #16's care plan dated 02/04/25 revealed: -He wandered. -He was sometimes disoriented with significant memory loss and had to be directed. -He was non-verbal. Review of Resident #16's incident/accident report dated 03/31/25 revealed: -He was noticed to be missing at 4:20pm. -He was found walking down the road in front of the facility by staff at 4:34pm. -The incident/accident happened on second shift. -The door company would be asked to assess the gate for a lock. Interview with a medication aide (MA) on 04/25/25 at 11:02am revealed: -Resident #16 walked out of the SCU when a personal care aide (PCA) had propped the exit door open. -Resident #16 walked out of the facility and out the secure gate. -He was picked up down the road by staff.	D 067		

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ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 067	Continued From page 13 Interview with a second MA on 04/28/25 at 11:24am revealed: -She was the MA in the SCU the day Resident #16 walked away. -The SCU exit door was not locked or alarmed at the time Resident #16 walked away; the door had been propped opened by a PCA. -The Special Care Coordinator (SCC) rode out to try and locate Resident #16; the SCC found him walking down the road. Telephone interview with a representative from a business who was to install maglocks on the exit door on 04/28/25 at 5:07pm revealed: -He was notified about 2 months ago to assess the need for a new maglock on the exit door of the SCU that led to the outside of the facility. -He wrote a contract and presented it to the Owner in less than two weeks; she signed the contract and put down a down-payment. -The Owner did not want the maglock placed on the SCU exit door at that time; she wanted to coordinate with another contractor who he thought was replacing the fire alarms. -The maglock on the SCU exit door had not been installed as of today, 04/28/25 Interview with the SCC on 04/29/25 at 8:05am and 11:13am revealed: -She was informed that the staff could not find Resident #16. -When she entered the SCU, she noticed the SCU exit door was open. -The PCA had disengaged the maglock and removed the cable from the door handle that was connected to the red box so the door would not alarm. -Some staff searched for Resident #16 on the property while she and another employee rode	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 067	Continued From page 14	D 067		

down the road to see if they could find him.
-She located Resident #16 about 1/10 a mile from the facility walking on the road.
-Resident #16 got in her car and she brought him back to the facility.
-The SCU staff knew how to disengage the alarm for the SCU exit door.
-She had instructed the staff not to disengage the SCU exit door.
-She placed a sign on the door with the instructions to not disengage the SCU door after Resident #16 left the facility.

Interview with the Regional Director (RD) on 04/28/25 at 8:17am revealed:
-Resident #16 walked out the SCU exit door.
-Staff had opened the back door and the alarm was not engaged.
-The staff know how to turn the alarm off on the SCU exit door.
-She did not know how long Resident #16 was gone before the staff noticed he was missing.
-She thought the delay in the entrance/exit gate was how Resident #16 got out of the gated community.

Interview with the Administrator on 04/24/25 at 4:06pm revealed:
-Two former PCAs opened the exit door in the SCU and propped it open.
-Resident #16 went out the SCU door when a PCA left the door open.
-Resident #16 went out of the entrance gate when it broke.
-The entrance gate was broken about 2 months ago and it took 2 days to get it repaired.
-She and the Maintenance Director watched the gate during the day so residents would not leave the facility.
-She and the Maintenance Director manually

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 067	Continued From page 15 closed the gate at night. Attempted telephone interviews with two former PCAs on 04/25/25 at 10:48 and 10:52am who propped the door open in the SCU were unsuccessful. Refer to the interview with the Maintenance Director on 04/24/25 at 3:03pm. Refer to the interview with the Administrator on 04/24/25 at 4:06pm. Refer to the interview with the Regional Director on 04/28/25 at 8:17am. _____ Interview with the Maintenance Director on 04/24/25 at 3:03pm revealed: -He checked all the exit doors daily to make sure they were alarmed. -He would check the doors during the day as he walked by them to ensure they were engaged to alarm. Interview with the Administrator on 04/24/25 at 4:06pm revealed: -All exit doors should be locked and alarmed. -The Maintenance Director was to check the exit doors every morning to ensure they were locked and alarmed. -Staff should randomly check the exit doors as they walk by them. Interview with the Regional Director on 04/28/25 at 8:17am revealed: -She was concerned about the residents' safety. -The highway in front of the facility was very busy; there was a lot of traffic. -She was concerned that a resident could get hit by a vehicle.	D 067		

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	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 067	Continued From page 16 -She expected the exit doors to remain alarmed for the safety of the residents. _____ The facility failed to ensure 3 of 3 exit doors in the AL and 1 of 1 exit door in the SCU, remained alarmed with a audible sounding device when the door was opened allowing residents with diagnoses of mental illness, cognitive deficits and dementia who were forgetful and intermittently and constantly confused to leave the facility. Two residents from the AL left the facility without staff knowledge, one who was picked up by staff walking down a busy highway and the other resident sitting on the front porch of a house, and one resident from the SCU left the facility and walked down a busy highway. The facility's failure resulted in a substantial risk for serious physical harm and neglect to the residents and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/24/25. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 29, 2025.	D 067		
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and	D 079		

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	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 079	Continued From page 17 existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to ensure that cleaning agents, laundry detergent, and other substances that may be hazardous if ingested or misused were kept in a separate locked area and not accessible to residents in the Special Care Unit (SCU). The findings are: Review of the facility's disclosure statement (undated) revealed: -All items such as toiletries and hygiene supplies would be in a secured and locked area for the safety of all residents. -All chemicals, cleaning products, and hazardous materials/waste would be kept out of reach of all the residents in a secure and locked area. -In case of an emergency, 911 would be called, poison control, and the primary physician. Observation of the hallway in the Special Care Unit (SCU) on 04/22/25 at 8:17am revealed: -There were 6 spray bottles of cleaning products and air fresheners on a cleaning cart. -The housekeeper was not within sight of the cleaning cart. Observation of a resident's room in the SCU on 04/22/25 at 8:17am revealed: -There was a bottle of isopropyl alcohol (used as	D 079		

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	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 079	Continued From page 18	D 079		

first aid to help prevent the risk of infection in minor cuts, scrapes, and burns) on a shelf beside the resident's bed.
-The warning label on the bottle of alcohol included the warning: for external use only. If taken internally, serious gastric disturbances would result. Do not get into the eyes, do not apply to large areas over the body, and do not use it for longer than one week unless directed by a doctor. In case of ingestion, get medical help or contact a poison control center right away.
-There was a bottle of cornstarch powder with aloe and vitamin E on a shelf beside the resident's bed.
-The warning label on the bottle of cornstarch powder included keeping powder away from the face to avoid inhalation, which could cause breathing problems. Avoid contact with eyes. For external use only.
-There was a bottle of body wash on top of the resident's dresser.
-The warning label on the body wash included to avoid contact with the eyes. In case of contact, flush thoroughly with water. If irritation developed, discontinue use.

Observation of the laundry room in the SCU on 04/22/25 at 8:18am revealed:
-The laundry room door was open and no staff were in the room or the hallway.
-There was one large bucket of powder laundry detergent without a lid sitting by a washing machine right inside the door.
-There were multiple buckets of the same product with lids sitting on the floor and on a shelf.

Review of the laundry detergent safety data sheet (SDS) revealed:
-The product could cause serious eye damage; prevention was to wear eye protection/face

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 079	Continued From page 19	D 079		

protection.
-If contact with the eyes, wash out the eyes with water for 15 minutes and get medical attention immediately.
-If contact with the skin, rinse with plenty of water.
-If swallowed, rinse the mouth and get medical attention if symptoms occurred.
-If inhaled, remove to fresh air, treat symptomatically, and seek medical attention if symptoms occurred.

Observation of a second resident's room in the SCU on 04/22/25 at 8:34am revealed:
-A bottle of alcohol-free mouthwash was sitting on a bedside table.
-The warnings on the label included in case of accidental ingestion, seek professional assistance or contact the poison control center immediately.

Observation of the housekeeping closet in the SCU on 04/22/25 at 8:34am revealed:
-The door was not locked and no staff were within sight of the closet.
-There were 3 containers of liquid cleaning products and 2 spray cans of glass cleaner.
-One of the cleaning product's warning label included, causes substantial but temporary eye injury. Do not get in eyes or clothing. Wear appropriate protective eyewear such as safety glasses. Wash thoroughly with soap and water after handling and before eating, drinking, chewing gum, using tobacco, or using the toilet. Remove and wash any contaminated clothing before reusing. If contact with the eyes, wash out the eyes with water for 15 minutes. Call the poison control center or doctor for treatment advice.
-A second cleaning product's warning label included may be harmful if swallowed. May cause

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 079	Continued From page 20	D 079		

skin irritation. Inhalation of vapors or mist may cause respiratory issues.
-The warning label on the window cleaner included harmful if inhaled.

Observation of a third resident's room in the SCU on 04/22/25 at 8:40am revealed:
-There was a bottle of body wash on top of the resident's dresser.
-The warning label on the body wash included to avoid contact with the eyes. In case of contact, flush thoroughly with water.

Observation of the shower room in the SCU on 04/22/25 at 8:58am revealed:
-The door to the shower room was open.
-There were multiple personal hygiene items sitting on an open shelf.
-There was a bottle of mouthwash and the warnings on the label included in case of accidental ingestion, seek professional assistance or contact a poison control center immediately.
-There were multiple bottles of lotions, shampoos, and body wash.

Observation of a fifth resident's room in the SCU on 04/22/25 at 10:15am am revealed:
-There was a bottle of alcohol-free mouthwash was sitting on a bedside table.
-The warnings on the label included if accidentally swallowed, seek professional assistance or contact the poison control center right away.

Observation of the SCU on 04/22/25 at various times from 8:14am-10:00am revealed:
-There were residents in the hallway.
-Residents were walking in and out of resident rooms and the shower room.
-There were no staff members seen in the

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	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 079	Continued From page 21 hallway in sight of the laundry room, housekeeping closet, and shower room. Interview with the laundry aide on 04/22/25 at 10:05am revealed: -She was the only staff member who did laundry. -The medication aides (MA) had keys to the laundry room. -The door to the laundry room was supposed to be locked at all times. -There had been times when she came in and the laundry room door was not locked. -Multiple residents wandered into the laundry room when she was in the room working and had to be redirected out. Interview with a personal care aide (PCA) on 04/22/25 at 10:25am revealed: -Multiple [named] residents wandered within the SCU. -The key to the laundry room was kept on the medication cart. -She had not seen any residents wander into the laundry room when the room was unattended. -The door to the shower room was kept unlocked. -Some residents had their own personal hygiene products. -The staff tried to keep the personal hygiene products put up because a [named] resident was known to go into other residents' rooms and "mess with their stuff." Interview with a second PCA on 04/22/25 at 10:35am revealed: -Two [named] residents would "mess" with other residents' things and had to be watched. -Personal hygiene items were supposed to be kept in the shower room or the office. -The laundry room was supposed to be locked at all times.	D 079		

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	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 079	Continued From page 22 -She had checked the laundry room door periodically and it was always locked. Interview with the housekeeper on 04/22/25 at 11:01am revealed: -He cleaned in the SCU. -The MAs had a key to the housekeeping closet. -He knew he had left the housekeeping closet unlocked today, 04/22/25, because he was going from rooms to the housekeeping closet to get cleaning items he did not keep on the cleaning cart. -He had found the housekeeping closet unlocked on two different occasions and had reported it to the Administrator. Second interview with the two PCAs on 04/22/25 at 10:51am revealed: -When staff saw personal hygiene items in a resident's room, they gave the items to the MA. -Staff looked for items that were not supposed to be in residents' rooms every day when they made rounds. Interview with the MA on 04/22/25 at 10:51am revealed: -There were 6 [named] residents who were known to wander in and out of rooms. -The PCAs were supposed to remove items from resident rooms and keep them locked in the closet in the shower room. -The shower room door was not locked, but there was a locked closet in the room. -She saw the personal hygiene items that were left on the shelf in the shower room today, 04/22/25, and she immediately locked the items in the closet. -The staff could get the key to the laundry room from the medication cart, but the staff knew the laundry room should be locked when they were	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 079	Continued From page 23	D 079		

finished.
-She had seen the housekeeping closet left unlocked.
-There were residents who might drink or eat things that were harmful because they would not know the difference.

Interview with the SCU Coordinator (SCC) on 04/22/25 at 10:39am revealed:
-There were three [named] residents that she knew went into other residents' rooms.
-If the laundry aide was not in the laundry room, she assumed the door would be locked.
-She had heard staff ask the MA for the key to the laundry room.
-Isopropyl alcohol should not be in a resident's room unless it was locked in the closet because it was a liquid and could be consumed, or a resident could get it into their eyes.
-Nothing potentially hazardous should be kept at the resident's bedside.
-The PCAs should remove items seen in a resident's room and notify the MA and/or her if items were seen in residents' rooms.
-It was very serious to have items accessible to residents because it was a hazard and put the residents in danger because all the residents in the SCU had dementia.

Interview with the Administrator on 04/22/25 at 12:29pm revealed:
-All personal care items should be locked in a cabinet.
-The laundry room door should be locked at all times.
-The cleaning supply closet should be locked at all times unless someone was standing at the door.
-Staff should be looking in resident rooms daily for items family members may have brought in.

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	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 079	Continued From page 24 -She was concerned items that could be hazardous were accessible to the residents in the SCU because the residents were constantly disoriented and might drink something they should not. Telephone interview with the facility's primary care provider (PCP) on 04/25/25 at 9:53am revealed: -She expected chemicals to be locked up. -She was concerned a resident could drink something they should not or accidentally spray something into their eyes. Telephone interview with the facility's mental health provider (MHP) on 04/25/25 at 4:50pm revealed: -She expected personal hygiene items and chemicals to be locked up, especially chemicals. -Because of the residents' cognition, personal hygiene items and chemicals would be dangerous to the residents. _____ The facility failed to ensure cleaning supplies, shampoos, shaving cream, lotions, and other items that could be hazardous to residents were secured when not monitored by staff, creating an unsafe environment for residents in the SCU. This failure was detrimental to the health and safety of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/22/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 13, 2025.	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 080	Continued From page 25	D 080		
D 080	10A NCAC 13F .0306 (a)(6) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (6) have a supply available in the facility at all times of bath soap, clean towels, washcloths, sheets, pillowcases, blankets, and additional covers such as a bedspread, comforter, or quilt for each resident to use; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to ensure the residents had soap, paper towels, and bed linens available for use at all times in the Assisted Living (AL). 1. Observation of resident bathrooms on A-hall on 04/22/25 between 8:30am and 10:00am revealed: -The bathroom had a paper towel dispenser. -Six bathrooms did not have paper towels in the dispenser or a hand towel for drying their hands. Observations of resident rooms on B-hall 04/22/25 at various times from 8:25am to 10:15am revealed: -Room #10 did not have paper towels or hand towels in the bathroom; three residents resided in the room. -Room #11 did not have paper towels or hand	D 080		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 080	Continued From page 26	D 080		

towels in the bathroom; two residents resided in the room.
-Room #12 did not have paper towels or hand towels in the bathroom; two residents resided in the room.
-Room #26 and room #27 shared a bathroom and it did not have paper towels or hand towels; room #26 had three residents residing in it and room #27 had one resident residing in it.

Interview with the two residents who resided in room #12 on 04/22/25 at 10:05am revealed:
-They never had paper towels in the bathroom.
-They would like paper towels in the bathroom.
-They dried their hands on their clothes or their used bath towels if they still had them.
-One resident used her bathrobe to dry her hands on.

Interview with a third resident who resided in room #27 on 04/22/25 at 8:45am revealed:
-The bathroom in her room did not have paper towels or cloth hand towels.
-She asked staff for paper towels but they did not always have them.
-There had not been paper towels in the bathroom for a while.
-She dried her hands on her clothes when she did not have paper towels.

Interview with a fourth resident who resided in room #27 on 04/23/25 at 7:59am revealed:
-There were not always paper towels in the bathroom.
-Most of the time she would come into the room and use her towel from her shower.
-She got a towel when she took her showers.
-She stopped asking for paper towels because staff never had them.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 080	Continued From page 27 Interview with a fifth resident on 03/11/25 at 2:35pm revealed he had to beg staff for towels and washcloths to complete his personal care. Interview with a sixth resident on 04/24/25 at 12:31pm revealed: -He did not recall ever having paper towels in the dispenser since living at the facility for 2 years. -He used his personal blanket on the back of his chair to dry his hands. -He did not ask for soap or paper towels any longer; he knew he would not get them. Interview with a seventh resident on 04/22/25 at 8:46am revealed it took 2-3 days for someone to bring him a towel and a washcloth. Interview with a eighth resident on 04/22/25 at 11:45am revealed: -He did not have paper towels in the dispenser. -He had a towel in his room to dry his hands. Interview with a resident's family member on 03/11/25 at 12:00pm revealed: -The resident was never given towels or washcloths. -The family provided all these items and had to purchase them. Interview with the housekeeper on 04/24/25 at 9:05am revealed: -He tried to keep paper towels in the dispensers in the residents' bathrooms. -The residents threw the paper towels into the toilet and clogged them up and caused them to overflow. -The Administrator told him he had to fill the paper towel dispensers because the residents had to have something to dry their hands on; they could not deny them a paper towel.	D 080		

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D 080	Continued From page 28 -He checked the paper towel dispensers every two days; he was due to check them today, 04/24/25. -They were out of paper towels in the facility for a day, but they got a delivery this morning, 04/24/25. Interview with a personal care aide (PCA) on 04/23/25 at 9:50am revealed she told the housekeeper when a resident told her they needed paper towels. Interview with the Resident Care Coordinator (RCC) on 04/28/25 at 9:30am revealed: -The housekeepers were responsible for filling the paper towel holders in the residents' bathrooms. -If a resident needed paper towels in their bathroom, they could let a PCA know. -The residents should not be without a paper towel to dry their hands after they washed their hands. Interview with the Administrator on 04/28/25 at 4:20pm revealed: -Replenishing the paper towels was the housekeeper's responsibility. -She did not know there were no paper towels in the residents' bathrooms for them to use to dry their hands. -The residents should have plenty of paper towels, hand towels and washcloths for use. -She had seen the linen closet and knew it was well stocked. -She was not aware it was an issue; staff had not informed her and residents had not complained 2. Observation of resident bathrooms on A-Hall 04/22/25 between 8:30am and 10:00am revealed: -The bathroom had a hand soap dispenser.	D 080		

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D 080	Continued From page 29 -Five resident bathrooms did not have soap in their dispensers. Observations of resident rooms on B-Hall 04/22/25 at various times from 8:25am to 10:15am revealed: -Room #10 did not have soap; three residents resided in the room. -Room #12 did not have soap; two residents resided in the room. Interview with the two residents who resided in room #12 on 04/22/25 at 10:05am revealed: -They did not have soap in their bathroom and could not remember the last time they had it. -They told the staff and were told the facility did not supply soap. -They were told to use wet wipes to wipe their hands. -There was a dispenser for soap on the wall, but it had never had soap in it. Interview with a third resident who resided in room #27 on 04/23/25 at 7:59am revealed: -She had never had soap in her bathroom. -Someone gave her soap as a gift one time and that was the only time she had some. -The soap dispenser on the wall never had soap in it and she was told by staff it did not work. Interview with a fourth resident on 04/24/25 at 12:31pm revealed: -He had lived at the facility for 3 years. -He never had soap in the soap dispenser. -He used his body wash to wash his hands. Interview with a fifth resident on 04/22/25 at 11:45am revealed: -He did not have soap in the soap dispenser. -The staff gave him a bar of soap yesterday to	D 080		

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D 080	Continued From page 30	D 080		

place in the shower.

Interview with the housekeeper on 04/24/25 at 9:05am revealed:
-Not all the residents' bathrooms had soap because the dispensers were broken.
-He had soap for the dispensers, but some were broken because the residents pushed too hard on them, and they broke.
-The facility was getting ready to change out the soap dispensers.
-There were clear windows on the soap dispensers so he could see the level of soap.
-He tried to check on the level of soap in the dispensers when he cleaned the bathrooms.
-He had not checked them in a couple of days.

Interview with a PCA on 04/23/25 at 9:50am revealed she told the housekeeper when a resident told her they needed soap.

Interview with the RCC on 04/28/25 at 9:30am revealed:
-The housekeepers were responsible for making sure there was soap in the residents' bathrooms.
-The PCAs could get soap from the housekeeper if a resident needed soap.
-Residents had not complained to her about needing soap.
-The residents needed soap in their bathrooms so they could wash their hands.

Interview with the Administrator on 04/28/25 at 4:20pm revealed:
-Replenishing the soap in the dispensers was the housekeeper's responsibility.
-She was not aware there was an issue with the lack of soap in the residents' bathrooms.
-The residents needed soap to be able to wash their hands after using the bathroom and before

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	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 080	Continued From page 31	D 080		

meals.
-Staff had not informed her residents were complaining about soap and residents had not complained about not having soap.

3. Observations of resident rooms in the in the AL on 04/22/25 at 8:25am revealed:
-There was a large dark spot and debris on the bottom sheet at the foot of one of the beds in resident room #26.
-There was large wet spot on the bottom sheet and underside of the blanket on the bed in room #12.

Observations of resident rooms in the AL on 04/23/25 at 7:55am revealed:
-There was no top sheet on the two beds in resident room #10.
-There was no top sheet on a bed in resident room #11.
-There was no top sheet on the two beds in resident room #12.
-There was a large wet spot on the bottom sheet and the underside of the blanket on one of the beds in room #12.
-There was no top sheet on a bed in resident room #26.

Interview with a resident's family member on 03/11/25 at 12:00pm revealed:
-The resident was never given bedding.
-The family provided all these items and had to repurchase bedding.
-When the resident returned from rehabilitation, all of his bedding that was purchased by the family was gone.
-No one could tell her where the resident's bedding was.

Interview with a resident who resided in room #10

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	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 080	Continued From page 32 on 04/28/25 at 11:30am revealed: -She would like to have a top and bottom sheet. -She only got a bottom sheet. -She had not thought to complain about it to any of the staff. Interview with a resident who resided in room #12 on 04/22/25 at 10:05am revealed: -She told the staff yesterday,04/21/25, about the large wet spot on her bed. -No one changed her bed after she told them. -Her sheets were changed two times a week. -Staff made her bed. Interview with a resident who resided in room #12 on 04/24/25 at 9:10am revealed: -She did not know why she did not have a top sheet on her bed. -She would have liked a top sheet. -Sometimes she had a top sheet and sometimes she did not. -Her sheets were changed two times a week. Interview with a resident who resided in room #27 on 04/23/25 at 7:59am revealed: -Her bed did not always have a top sheet on it. -She would like to have a top sheet on her bed. -Her bottom sheet was not fitted, and it slid off the bed so sometimes all she had was a blanket at night. Interview with a resident who resided in room #27 on 04/22/25 at 8:45am revealed: -The staff changed her bed linens about once a week. -She would lay on her bed with her shoes on when she took a nap. -She had not noticed the dark spot or the debris on her sheets.	D 080		

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D 080	Continued From page 33 Interview with a personal care aide (PCA) 04/24/25 at 9:35am revealed: -The facility had mainly flat sheets. -The PCAs changed the residents' sheets if they were soiled. -The residents' bed were changed on their shower days but they were changed almost every day because most of the time they were soiled. -Every bed was made with two sheets and a cover. -Some of the residents took their top sheet off; they stuffed them under the bed or brought them to the PCAs. -She always put a top sheet on the residents' beds. -She had not noticed the soiled sheets in resident room #12 or #26. Interview with a medication aide (MA) on 04/25/25 at 11:45am revealed: -The PCAs changed the residents' bed linens every day. -Each bed got a top sheet, a bottom sheet, a blanket and a pillowcase. -Residents had not complained to her about not having a top sheet. -She had not heard of a resident removing the top sheet from their bed. Interview with the laundry staff on 04/24/25 at 12:18pm revealed: -She washed sheets every day. -She had a hard time keeping up with the laundry due to the amount of bed sheets she washed every day. -She had plenty of flat sheets but not as many of the fitted sheets. -The PCAs changed the residents' bed linens and were supposed to use a top and bottom sheet.	D 080		

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D 080	Continued From page 34 Interview with the Administrator on 04/28/25 at 4:20pm revealed: -The linen closet was full of sheets. -Beds were changed on shower days or as they got dirty. -Residents' beds should have a top and bottom sheet. -She did rounds in the mornings and she could see 2 sheets on every bed. -She did not know why the residents were not asking for a top sheet. -Residents had not complained to her about not having a top sheet. _____ The facility failed to ensure residents residing in the Assisted Living had a supply of soap, paper towels, and bed lines at all times, resulting in the residents not having soap to wash their hands after toileting and drying their hands off on their clothing, and residents lying on wet or soiled bed linens. This failure was detrimental to the health and safety of the residents and constitutes a Type B Violation. _____ A plan of protection in accordance with G.S. 131D-34 was requested on 05/20/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 13, 2025.	D 080		
D 089	10A NCAC 13F .0306 (b)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (b) Each bedroom shall have the following	D 089		

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ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 089	Continued From page 35 furnishings in good repair and clean for each resident: (3) chest of drawers or bureau when not provided as built-ins, or a double chest of drawers or double dresser for two residents; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to furnish a dresser for 7 residents in the assisted living (AL) and 5 resident in the special care unit (SCU). The findings are: 1. Observation of the room #2 on 04/22/25 between 8:30am and 10:00am revealed: -There were four residents residing in room #2. -There were three dressers with 3 drawers in the room. Interview with a resident who resided in room #2 on 04/22/25 at 11:48am revealed: -He used one of the dressers for his clothes. -He did not know who used the other two dressers. Interview with another resident who resided in room #2 on 04/22/25 at 11:52am revealed: -There were only three dressers in the room. -He and another resident shared a dresser. Observation of room #3 revealed: -There were three residents residing in the room. -There were 2 dressers in the room with 3 drawers.	D 089		

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D 089	Continued From page 36 Interview with resident who resided in room #3 on 04/24/25 at 11:41am revealed: -He did not have a dresser to use. -He had a closet and a nightstand by his bed. -The two dressers in the room were used by the other two residents in the room. Observation of room #31 revealed: -There were three resident residing in room #31. -There was one dresser in the room for 3 residents. Attempted interview with Resident #6 on 04/22/25 at 9:15am was unsuccessful. Observation of room #34 revealed: -There were two residents residing in the room. -There was 1 dresser with 3 drawers in the room. Interview with a resident who resided in room #34 on 04/22/25 at 11:41am revealed: -He did not have a dresser for his clothes. -He placed his clothes in the closet. Observation of room #26 on 04/22/25 at 10:15am revealed: -There were three residents residing in resident room #26. -There was one tall dresser with six drawers. -There were folded clothes on the floor on either side of the dresser. -There were three closets in the room. -One of the closets had folded and unfolded clothes on the floor that spilled out when the closet door was opened. Interview with two residents who resided in room #26 on 04/23/25 at 7:58am revealed: -They shared the dresser in the room. -They each had three drawers.	D 089		

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D 089	Continued From page 37 -There was not enough room to store all their clothes, so they placed some on the floor. -The third roommate did not speak English, so she did not complain about not having a dresser. -The third roommate put her clothes in her closet. -They had not complained about not having another dresser; it had been only one dresser since they moved into the room. Interview with the Maintenance Director 04/28/25 at 11:30pm revealed: -He only found out about the dresser requirements last week. -He was going around the AL and counting dressers to see how many needed to be ordered. Interview with the Administrator on 04/28/25 at 4:00pm revealed: -She had not looked at the dressers in the AL. -She knew each resident was required to have a dresser. -She thought the closet space was enough until she addressed the dressers. 2. Observation of the first room on the left in the SCU on 04/22/25 at 9:59am revealed: -The room was not numbered. -There were two residents listed on the plaque outside the door. -There were 3 beds in the room. -There was 1 dresser with 5 drawers in the room. Interview with a resident who resided in this room on 04/23/25 at 8:28am revealed he did not have a dresser and did not know which resident used the dresser in the room. Observation of room #1 on 04/22/25 at 10:22am revealed: -There were three residents listed on the plaque	D 089		

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D 089	Continued From page 38	D 089		

outside the door.
-There were 3 beds in the room.
-There was 1 dresser with 6 drawers in the room; the drawers were labeled with 2 of the residents' names.

Based on observations and interviews the residents who resided in room #1 were not interviewable.

Observation of room #2 on 04/22/25 at 10:14am revealed:
-There was one resident listed on the plaque outside the door.
-There were 2 beds in the room.
-There was 1 dresser with 5 drawers in the room, one of the drawers was missing.

Based on observations and interviews, the resident who resided in room #2 was not interviewable.

Observation of room #7 on 04/22/25 at 10:24am revealed:
-There were 2 beds in the room.
-There was 1 bedside table.
-There was 1 dresser.

Interview with a resident, who resided in room #7, on 04/23/25 at 8:37am revealed he did not have a roommate "right now", but he would need another dresser in the room when he had a roommate.

Observation of room #8 on 04/22/25 at 10:31am revealed there were 2 beds and 1 dresser.

Interview with a resident, who resided in room #8, on 04/22/25 at 10:31am revealed he shared a dresser with his roommate but he would like to have one of his own.

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	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 089	Continued From page 39 Interview with a medication aide (MA) on 04/24/25 at 8:12am revealed: -Some of the residents shared a dresser. -If there was a 6-drawer dresser in the room, one resident would get 3 drawers and the other resident would get the other 3 drawers. Interview with a second MA on 04/24/25 at 3:36pm revealed she thought some of the residents used the drawers on their bedside table in place of dresser drawers. Interview with the Maintenance Director on 04/24/25 at 3:00pm revealed: -He knew one of the resident's dressers was missing a drawer. -He had noticed some of the residents needed dressers and he was working on it. -There were dressers in storage that could be placed in the residents' rooms. Interview with the SCU Coordinator (SCC) on 04/24/25 at 4:04pm revealed: -She thought every room should have the basics which would include a dresser. -She had not taken an inventory of what each resident had or needed. Interview with the Administrator on 04/29/25 at 4:53pm revealed: -Every resident should have a dresser. -She had not been to the SCU and noted who needed dressers. -There should have been dressers in the residents' rooms.	D 089		
D 091	10A NCAC 13F .0306 (b)(5)(6) Housekeeping And Furnishings	D 091		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 091	Continued From page 40 10A NCAC 13F .0306 Housekeeping And Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (5) a minimum of one chair that is comfortable as preferred by the resident, which may include a rocking or straight chair, with or without arms, that is high enough for the resident to easily rise without discomfort; (6) additional chairs available, as needed, for use by visitors; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to furnish a chair for 15 of 17 residents in the special care unit (SCU) and 15 of 24 residents in the assisted living (AL). The findings are: 1. Observation of the first room on the left in the SCU on 04/22/25 at 9:59am revealed: -The room was not numbered. -There were two residents listed on the plaque outside the door. -There were 3 beds in the room. -There were no chairs in the room. Observation of a resident who resided in this room on 04/23/25 at 8:28am revealed the resident was sitting on the side of his bed. Interview with this resident on 04/23/25 at 8:28am	D 091		

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	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 091	Continued From page 41 revealed he wished he had a chair to sit in in his room. Observation of room #1 on 04/22/25 at 10:22am revealed: -There were three residents listed on the plaque outside the door. -There were 3 beds in the room. -There were no chairs in the room. Based on observations and interviews the residents who resided in room #1 were not interviewable. Observation of room #2 on 04/22/25 at 10:14am revealed: -There was one resident listed on the plaque outside the door. -There were 2 beds in the room. -There was one chair on the other side of the room, by the door. Observation of a resident in room #2 on 04/22/25 at 8:55am revealed he was sitting on the side of the bed with a bedside table pulled up for him to eat his breakfast. Based on observations and interviews the resident who resided in room #2 was not interviewable. Observation of room #3 on 04/22/25 at 10:04am revealed: -There were two residents listed on the plaque outside the door. -There were no chairs in the room. Observation of the two residents who resided in room #3 on 04/22/25 at various times between 9:00am and 3:00pm revealed:	D 091		

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D 091	Continued From page 42 -Both residents were ambulatory. -Both residents were lying down on their beds when in their rooms. Based on observations and interviews the residents who resided in room #3 were not interviewable. Observation of room #4 on 04/22/25 at 8:36am revealed: -There were two residents listed on the plaque outside the door. -There were 2 beds in the room. -There were no chairs in the room. Observation of one of the residents who resided in room #4 on 04/22/25 at various times between 9:00am and 3:00pm revealed: -She was ambulatory. -She laid down on her bed when in her room. Interview with one of the residents in room #4 on 04/22/25 at 11:05am revealed she had never had a chair in her room, but it would be nice. Observation of room #5 on 04/22/25 at 10:12am revealed: -There were two residents listed on the plaque outside the door. -There were 2 beds in the room. -There were no chairs in the room. Based on observations and interviews the residents who resided in room #5 were not interviewable. Observation of room #6 on 04/22/25 at 11:18am revealed: -There were two residents listed on the plaque outside the door.	D 091		

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D 091	Continued From page 43 -There were 2 beds in the room. -There was one chair in the room. Based on observations and interviews, the resident who resided in room #6 was not interviewable. Observation of room #7 on 04/22/25 at 10:24am revealed: -There were 2 beds in the room. -There were no chairs in the room. Observation of one of the residents who resided in room #7 on 04/22/25 at various times between 9:00am and 3:00pm revealed the Resident #7 used a wheelchair. Interview with a resident who resided in room #7 on 04/23/25 at 8:37am revealed he would like to have something other than his wheelchair to sit in. Observation of room #8 on 04/22/25 at 10:31am revealed: -There were 2 beds, 2 bedside tables, and 1 dresser. -There were no chairs in the room. Interview with a resident who resided in room #8 on 04/22/25 at 10:31am revealed: -He would like to have a chair in his room. -He always had to lie down on his bed, but he would like to sit up. -He had not had a chair in his room since he was admitted. Interview with a medication aide (MA) on 04/24/25 at 8:12am revealed: -The residents who resided in the SCU did not have chairs in their rooms.	D 091		

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D 091	Continued From page 44 -She did not know the rooms were required to have a chair for each resident. Interview with a second MA on 04/24/25 at 3:36pm revealed the residents did not have chairs in their room; most of the residents would lay on their beds. Interview with the Special Care Unit Coordinator (SCC) on 04/24/25 at 4:04pm revealed: -She thought every room should have the basics which would include a chair. -She did not know why there were resident rooms without chairs. -She had not taken an inventory of what each resident had or needed. Interview with the Maintenance Director on 04/24/25 at 3:00pm revealed he did not know it was a requirement for each resident to have a chair in their room. Interview with the Administrator on 04/29/25 at 4:53pm revealed she had not been to the SCU and noted who needed chairs. Refer to the interview with the Maintenance Director on 04/24/25 at 3:00pm. Refer to the interview with the Administrator on 04/29/25 at 4:53pm. 2. Observation of the room #2 on the A-hall on 04/22/25 between 8:30am and 10:00am revealed: -There were 4 residents residing in room #2. -There were 4 beds and 3 chairs in the room. Interview with a resident, who resided in room #2, on 04/22/25 at 11:48am revealed:	D 091		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 091	Continued From page 45 -He laid on his bed when he was in his room. -He would go outside to the smoking area to sit in a chair. Observation of room #3 on the AL revealed: -There were 3 residents residing in the room. -There were 3 beds and one chair in the room. Interview with a resident, who resided in room #3, on 04/24/25 at 11:41am revealed: -He did not have a chair to sit in in his room. -There were chairs in the common area and outside for him to sit in. -He would like to have a chair in his room. Observation of room #6 revealed: -There were 3 residents residing in the room. -There were 3 beds and one chair in the room. Attempted interview with a resident who resided in room #6 on 04/22/25 at 9:22am was unsuccessful. Observation of room #31 revealed: -There were 3 residents residing in the room. -There were 3 beds and no chairs in the room. Attempted interview with a resident who resided in room # 31 on 04/22/25 at 9:15am was unsuccessful. Observation of room # 34 revealed: -There were two residents residing in the room. -There were 2 beds and no chairs in the room. Interview with a resident, who resided in room #34, on 04/22/25 at 11:41am revealed: -There were no chairs in his bedroom. -He would sit on his bed when he was in his bedroom.	D 091		

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D 091	Continued From page 46 -He would like to have a chair in his room. Observation of resident room #10 on 04/22/25 from 8:33am revealed: -There were three residents residing in room #10. -There were no chairs in the room. Interview with a resident who resided in room #10 on 04/22/25 at 10:15am revealed: -She sat on her bed when she wanted to sit in her room. -Visitors would use the rollator walker in the room to sit because there was no chair. -Her roommates also sat on their beds because there was nowhere to sit. -She would sit in a chair if she had one. Observation of room #11 on 04/22/25 from 8:33am revealed: -There were two residents residing in room #11. -There were no chairs in the room. Interview with a resident, who resided in resident room #11, on 04/28/25 at 11:30am revealed she would like a chair in her room to sit on. Observation of room #12 on 04/22/25 from 8:36am revealed: -There were two residents residing in room #12. -There was one chair in the room. Interview with a resident who resided in room #12 on 04/25/25 at 1:42pm revealed: -She would like to have a chair in her room for visitors to sit on. -Her roommate had a chair, but no one could use it because there were personal belongings on it. Observation of room #26 on 04/22/25 from 8:33am 10:15 revealed:	D 091		

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D 091	Continued From page 47 -There were three residents residing in resident room #26. -There were no chairs in the room. Interview with two residents, who resided in room #26, revealed on 04/23/25 at 8:00am revealed: -They had not thought about having a chair in their room. -It would be nice for them to each have a chair to sit in or use. -They both sat on their beds when they were in their room. -One of them had lived in another room with a chair and they used it so it would be nice to have one in this room. Refer to the interview with the Maintenance Director on 04/24/25 at 3:00pm. Refer to the interview with the Administrator on 04/29/25 at 4:53pm. _____ Interview with the Maintenance Director on 04/24/25 at 3:00pm revealed he did not know it was a requirement for each resident to have a chair in their room. Interview with the Administrator on 04/29/25 at 4:53pm revealed: -Every resident should have a chair. -There should have been chairs in the residents' rooms.	D 091		
D 093	10A NCAC 13F .0306 (b)(8) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings	D 093		

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D 093	Continued From page 48 (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (8) a light overhead of bed with a switch within reach of person lying on bed; or a lamp. The light shall provide a minimum of 30 foot-candle power of illumination for reading. Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide each bedroom with a light above the bed with a switch within reach of the resident for 13 of 17 residents residing in the special care unit (SCU). The findings are: Observation of the first room on the left on 04/22/25 at 9:59am revealed: -The room was not numbered. -There were two residents listed on the plaque outside the door. -There were 3 beds in the room. -No lamps were observed in the room for the residents to use when in bed. -There was no light above the three beds within reach of the residents. Interview with a resident who resided in the room on 04/23/25 at 8:28am revealed he had to walk across the room to turn on a light. Observation of room #1 on 04/22/25 at 10:22am revealed: -There were three residents listed on the plaque outside the door.	D 093		

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D 093	Continued From page 49 -There were 3 beds in the room. -No lamps were observed in the room for the residents to use when in bed. -There was no light above the three beds within reach of the residents. Based on observations and interviews the residents who resided in room #1 were not interviewable. Observation of room #3 on 04/22/25 at 10:04am revealed: -There were two residents listed on the plaque outside the door. -One of the residents had a lamp on his bedside table. -There was no lamp observed for the second resident to use when in bed. -There was no light above the bed with a switch within reach of the resident. Based on observations and interviews the residents who resided in room #3 were not interviewable. Observation of room #4 on 04/22/25 at 8:36am revealed: -There were two residents listed on the plaque outside the door. -There were 2 beds in the room. -There was a lamp on the dresser which was not within reach of the resident when in bed. -There was no light above the two beds within reach of the residents. Interview with one of the residents who resided in room #4 on 04/22/25 at 11:05am revealed that she would like to have her lamp beside her bed, but she did not have a bedside table to put it on.	D 093		

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D 093	Continued From page 50 Observation of room #5 on 04/22/25 at 10:12am revealed: -There were two residents listed on the plaque outside the door. -There were 2 beds in the room. -No lamps were observed in the room for the residents to use when in bed. -There was a wall light above both beds, but one of the lights was not working. Based on observations and interviews the residents who resided in room #5 were not interviewable. Observation of room #6 on 04/22/25 at 11:18am revealed: -There were two residents listed on the plaque outside the door. -There were 2 beds in the room. -No lamps were observed in the room for the residents to use when in bed. -There was no light above the beds with a switch within reach of the residents. Interview with a resident who resided in room #6 on 04/23/25 at 11:09am revealed: -She asked a staff member to turn her overhead light off and on. -She would like a lamp by her bedside. Based on observations and interviews, the other resident who resided in room #6 was not interviewable. Observation of room #7 on 04/22/25 at 10:24am revealed: -There were 2 beds in the room. -No lamps were observed in the room for the residents to use when in bed. -There was no light above the two beds within	D 093		

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	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 093	Continued From page 51 reach of the residents. Interview with a resident who resided in room #7 on 04/23/25 at 8:37am revealed: -He could not reach the light switch from his bed. -He would like to have a lamp by his bedside. Observation of room #8 on 04/22/25 at 10:31am revealed: -There were 2 beds, 2 bedside tables, and 1 dresser. -No lamps were observed in the room for the residents to use when in bed. -There was no light above the two beds within reach of the residents. Interview with a resident who resided in room #8 on 04/22/25 at 10:31am revealed that he would like to have a lamp in his room. Interview with a medication aide (MA) on 04/24/25 at 8:12am revealed: -She knew the residents needed to be able to reach a light from their bed. -The residents did not have lamps in their rooms. Interview with the Special Care Unit Coordinator (SCC) on 04/24/25 at 4:04pm revealed: -She thought every room should have the basics, which would include a lamp or a light within reach of the bed. -She had not taken an inventory of what each resident had or needed. Interview with the Maintenance Director on 04/24/25 at 3:00pm revealed he did not know it was a requirement for each resident to have a lamp or a light they could reach from their bed in their room.	D 093		

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D 093	Continued From page 52 Interview with the Administrator on 04/29/25 at 4:53pm revealed: -Every resident should have a lamp. -She had not been to the SCU and noted who needed lamps. -There should have been lamps in the residents' rooms.	D 093		
D 094	10A NCAC 13F .0306 (c) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (c) The living room shall have living room furnishings that are in good working order and provide comfort as preferred by residents with coverings that are easily cleanable. Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the furnishings in the television room in the Assisted Living (AL) were in good repair as evidenced by two lamps that did not have bulbs or shades on them. The findings are: Observation of the television room in the AL on 04/22/25 at various times from 10:00am to 4:00pm revealed: -There was a small television room with two sofas and two tables with plugs and lamps built into them.	D 094		

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D 094	Continued From page 53 -The lamps were plugged into the wall outlet. -There were no shades on the lamps and there were no bulbs screwed into the lamps socket. -At 10:33am, there were two residents in the room watching television. -At 12:40pm, there was a resident in the room asleep. -At 4:00pm, there were two residents in the television room. Interview with a personal care aide (PCA) on 04/24/25 at 2:20pm revealed: -She had not noticed the lamps in the television room did not have bulbs or shades. -She saw residents sitting in the room every day. Interview with the Maintenance Director on 04/24/25 at 2:10pm revealed: -He went into the television room in the AL every morning to check the door alarms. -The two lamps in the room worked. -About a month ago he put bulbs in them, but they started to flicker and there was a "frying" sound; the combination let him know there was a short in the lamps. -He took the bulbs out and unplugged the lamps. -He meant to throw the lamps away and got busy with other things and forgot about them. -He thought a resident might have plugged the lamps back into the wall outlet. -The lamps were dangerous if they were plugged in and did not have a bulb in the socket. -A resident could touch the socket and get shocked. Interview with the Administrator on 04/28/25 at 4:20pm revealed: -She had thrown away a set of tables and lamps from the television room in the AL at the beginning of March 2025.	D 094		

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D 094	Continued From page 54 -She thought the tables and lamps set currently in the television room were a set she moved into an empty room for storage; she did not know how they ended up in the television room. -The lamps in the television room should not have been left plugged in without a bulb because they were not safe. -She was not aware they did not work. -The residents were always messing with things in the facility and could accidentally put their finger and the socket and shock themselves.	D 094		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or moving into an adult care home, the administrator, all other staff, and any persons living in the adult care home shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205, which is hereby incorporated by reference, including subsequent amendments. Amended Eff. July 1, 2021 This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure 2 of 8 sampled staff (C and H) were tested for tuberculosis (TB) disease upon hire. The findings are: Review of the facility's Personnel Policies and Rules and Regulations dated August 2016 revealed applicants shall provide documentation of a two-step TB skin test upon hire and another skin test after two weeks of employment.	D 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 131	Continued From page 55 1. Review of Staff C's, medication aide (MA), personnel record revealed: -She was hired on 03/07/25. -There was no documentation of a TB skin test having been completed. Interview with Staff C on 04/28/25 at 7:08pm revealed: -She started working at the facility in March of 2025. -She remembered having her first step TB skin test administered when she started working at the facility. Interview with the Administrator on 04/29/25 at 4:12pm revealed she thought Staff C had her TB skin tests completed upon hire. Refer to the interview with the Administrator on 04/29/25 at 4:12pm. 2. Review of Staff H's, personal care aide (PCA), personnel record revealed: -She was hired on 04/09/25. -There was no documentation of a TB skin test having been completed. Interview with the Administrator on 04/29/25 at 4:12pm revealed: -She could not locate a TB skin test in Staff H's personnel record. -She thought Staff H had her TB skin test completed upon hire. Attempted telephone interview with Staff H on 04/28/25 at 7:52pm was unsuccessful. Refer to the interview with the Administrator on 04/29/25 at 4:12pm.	D 131		

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D 131	Continued From page 56 Interview with the Administrator on 04/29/25 at 4:12pm revealed: -The Licensed Health Professional Support (LHPS) nurse was responsible for ensuring staff TB skin tests were completed prior to hire. -When new staff were hired, she gave the staff paperwork to take to the LHPS nurse to obtain the first and a second TB skin test.	D 131		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure 3 of 8 sampled staff (C, G, H) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) upon hire. The findings are: Review of the facility's Personnel Policies and Rules and Regulations dated August 2016 revealed a HCPR check would be conducted on any new employee as required by State Law. 1. Review of Staff C's personnel record revealed: -Staff C was hired on 03/07/25 as a medication	D 137		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 137	Continued From page 57	D 137		

aide (MA).
-There was no documentation a HCPR review was completed upon hire.
-On 04/29/25, the HCPR review was completed and there were no substantiated findings.

Interview with Staff C on 04/28/25 at 7:08pm revealed:
-She had worked at the facility for about two months.
-She did not know what the HCPR was.
-She did not know if the facility checked the HCPR.

Interview with the Administrator on 04/29/25 at 4:12pm revealed:
-She did not know the HCPR had not been checked for Staff C.
-Staff C's HCPR should have been checked prior to hire.

Refer to the interview with the Administrator on 04/29/25 at 4:12pm.

2. Review of Staff G's personnel record revealed:
-Staff G was hired on 03/15/25 as a personal care aide (PCA).
-There was no documentation a HCPR review was completed upon re-hire.
-On 04/29/25, the HCPR review was completed and there was a substantiated finding of Fraud Against a Resident and was entered on the Registry on 04/02/01.

Interview with Staff G on 04/28/25 at 8:43pm revealed:
-She had worked at the facility for 4 years before she was re-hired last month.
-She did not know what the HCPR was.
-She did not know if the facility checked the

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	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 137	Continued From page 58 HCPR. Interview with the Administrator on 04/29/25 at 4:12pm revealed: -She did not know the HCPR had not been checked for Staff G. -Staff G's HCPR should have been checked prior to re-hire. -She ran a check on Staff G on 04/28/25 and there was one substantiated finding on the HCPR. -Staff G was terminated on 04/28/25. Refer to the interview with the Administrator on 04/29/25 at 4:12pm. 3. Review of Staff H's personnel record revealed: -Staff H was hired on 04/09/25 as a personal care aide (PCA). -There was no documentation a HCPR review was completed upon hire. -On 04/29/25, the HCPR review was completed and there were no substantiated findings. Interview with the Administrator on 04/29/25 at 4:12pm revealed: -She did not know the HCPR had not been checked for Staff H. -Staff H's HCPR should have been checked prior to hire. Attempted telephone interview with Staff H on 04/28/25 at 7:52pm was unsuccessful. Refer to the interview with the Administrator on 04/29/25 at 4:12pm. _____ Interview with the Administrator on 04/29/25 at 4:12pm revealed the office staff were responsible for ensuring the HCPR was checked.	D 137		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 137	Continued From page 59 The facility failed to ensure 3 of 8 sampled staff had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) upon hire, including one staff who had a substantiated finding. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/29/25 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 13, 2025.	D 137		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check completed in accordance with G.S. 131D-40 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 8 sampled staff (G) had a criminal background check completed upon hire. The findings are: Review of the facility's Personnel Policies and Rules and Regulations dated August 2016 revealed prior to beginning work, all applicants shall obtain a criminal background check.	D 139		

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	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 139	Continued From page 60 Review of Staff G's, personal care aide (PCA), personnel record revealed: -Staff G was previously hired on 07/03/23. -A new date of hire of 03/15/25 was documented. -There was a criminal background check completed on 07/03/23. -There was no documentation that a criminal background check was completed for the most recent hire date. Telephone interview with Staff G on 04/28/25 at 8:43pm revealed: -She worked at the facility as a PCA. -She worked at the facility off and on for years and returned to work last month. -She did not have a criminal background check completed when she was re-hired. -The facility had her criminal background check from the first time she was hired at the facility. -She had not committed any crimes and so there was no need for the facility to do another criminal background check. Interview with the Administrator on 04/29/25 at 4:12pm revealed: -She was responsible for completing Staff G's criminal background check. -She thought Staff G had a completed criminal background check in her personnel record. -She could not locate a criminal background check in Staff G's personnel record.	D 139		
D 140	10A NCAC 13F .0407(a)(8) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (8) have an examination and screening for the	D 140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 140	Continued From page 61 presence of controlled substances completed in accordance with G.S. 131D-45 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure documentation of an examination and screening for the presence of controlled substances was completed for 1 of 8 sampled staff (G). The findings are: Review of the facility's Personnel Policies and Rules and Regulations dated August 2016 revealed all applicants shall submit to a drug test prior to hire and if tested positive, the applicant would be ineligible for employment. Review of Staff G's, personal care aide (PCA), personnel record revealed: -Staff G was hired on 03/15/25. -There was no documentation Staff G completed a drug screening when she was hired. Telephone interview with Staff G on 04/28/25 at 8:43pm revealed she thought she had completed a drug screen when she was re-hired. Interview with the Administrator 04/29/25 at 4:12pm revealed: -She was responsible for completing drug screenings for all new staff. -She thought Staff G had a drug screening in her personnel record. -She could not locate a drug screening in Staff G's personnel record.	D 140		

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	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 194	Continued From page 62	D 194		
D 194	10A NCAC 13F .0608 (a)(b) Staffing for Facilities With A Census Of 21 10A NCAC 13F .0608 Staffing for Facilities With A Census Of 21 Or More Residents (a) Each facility with a census of 21 or more residents shall have staff on duty to meet the needs of the residents. (b) In addition to the requirement in Paragraph (a) of this Rule, each facility with a census of 21 or more residents shall comply with the following staffing requirements: (1) On first shift and second shift, the total aide duty hours shall be at least: (A) 16 hours of aide duty for facilities with a census of 21 to 40 residents. (B) 20 hours of aide duty for facilities with a census of 41 to 50 residents. (C) 24 hours of aide duty for facilities with a census of 51 to 60 residents. (D) 28 hours of aide duty for facilities with a census of 61 to 70 residents. (E) 32 hours of aide duty for facilities with a census of 71 to 80 residents. (F) 36 hours of aide duty for facilities with a census of 81 to 90 residents. (G) 40 hours of aide duty for facilities with a census of 91 to 100 residents. (H) 44 hours of aide duty for facilities with a census of 101 to 110 residents. (I) 48 hours of aide duty for facilities with a census of 111 to 120 residents. (J) 52 hours of aide duty for facilities with a census of 121 to 130 residents. (K) 56 hours of aide duty for facilities with a census of 131 to 140 residents. (L) 60 hours of aide duty for facilities with a census of 141 to 150 residents.	D 194		

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D 194	Continued From page 63 (M) 64 hours of aide duty for facilities with a census of 151 to 160 residents. (N) 68 hours of aide duty for facilities with a census of 161 to 170 residents. (O) 72 hours of aide duty for facilities with a census of 171 to 180 residents. (P) 76 hours of aide duty for facilities with a census of 181 to 190 residents. (Q) 80 hours of aide duty for facilities with a census of 191 to 200 residents. (R) 84 hours of aide duty for facilities with a census of 201 to 210 residents. (S) 88 hours of aide duty for facilities with a census of 211 to 220 residents. (T) 92 hours of aide duty for facilities with a census of 221 to 230 residents. (U) 96 hours of aide duty for facilities with a census of 231 to 240 residents. (2) On third shift, the total aide duty hours shall be at least: (A) 8 hours of aide duty for facilities with a census of 21 to 30 residents. (B) 16 hours of aide duty for facilities with a census of 31 to 60 residents. (C) 24 hours of aide duty for facilities with a census of 61 to 90 residents. (D) 32 hours of aide duty for facilities with a census of 91 to 120 residents. (E) 40 hours of aide duty for facilities with a census of 121 to 150 residents. (F) 48 hours of aide duty for facilities with a census of 151 to 180 residents. (G) 56 hours of aide duty for facilities with a census of 181 to 210 residents. (H) 64 hours of aide duty for facilities with a census of 211 to 240 residents. (3) If the Department determines the needs of the residents at a facility are not being met by staffing requirements of Paragraph (b) of this	D 194		

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	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 194	Continued From page 64 Rule, the Department shall require the facility to employ staff to meet the needs of the residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to meet the minimum required aide hours to meet the needs of residents residing in the Assisted Living (AL) for 6 of 27 sampled shifts from 02/14/25 to 04/25/25. The findings are: Review of the facility's current license effective 01/01/25 revealed the facility was an Adult Care Home with a capacity for 86 residents, 20 of which were Special Care Unit beds. Review of the facility's census dated 04/22/25 revealed a census of 38 residents residing in the AL. Review of the facility's undated Staff Scheduling Policy revealed: -The facility would maintain a posted staffing schedule that ensured qualified staff were available at all times to meet the care needs of residents. -Scheduling would be done fairly, predictably, and	D 194		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 194	Continued From page 65 according to the staffing requirements outlined by the North Carolina Division of Health Service Regulation (DHSR). Interview with a resident on 03/11/25 at 2:35pm revealed: -Most days there was only one staff member, if any, on the halls. -The staff were always too busy smoking cigarettes or talking to the other staff to help the residents. -He went to the Administrator about not receiving medications as scheduled; the Administrator replied the facility had staffing issues. Interview with a second resident on 04/10/25 at 1:13pm revealed he did not report not getting medications because the facility was aware when there were no medication aides (MA) in the facility. Interview with a third resident on 04/28/25 at 4:22pm revealed: -He would yell when he needed assistance. -If no one came, he would walk to the common area and yell for the staff. -Sometimes a staff would appear, and other times no staff would appear. -Some nights there would be no MA in the facility from 9:00pm to 12:00am. -The weekends were [expletive]; there were not enough staff, and the MAs would come in late and leave early on their shift. Confidential interview with a staff member revealed: -The facility was "short staffed a lot". -On two unknown dates there were not any MAs in the facility	D 194		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 194	Continued From page 66 Review of the census and punch cards for staff on 02/14/25 revealed: -There was a census of 45 residents, which required 20 aide hours on first and second shifts. -There was a total of 15.50 aide hours provided on first shift leaving a shortage of 4.5 aide hours. -There was a total of 8.25 aide hours provided on second shift leaving a shortage of 11.75 aide hours. Interview with a family member on 04/24/25 at 8:35am revealed: -Her family member called her 5 to 6 times on 02/14/25 crying and complaining of pain. -Her family member said there was no MA in the facility to administer medications on first or second shift. -Her family member had terminal cancer and needed his pain medications. -She called the facility and spoke with a personal care aide (PCA) and was told there was no MA in the facility to administer medications and she could not administer medications because she was a PCA. -She attempted to call the Administrator without success. -She called the previous Resident Care Coordinator (RCC) who said she would take care of it. -She was informed later that a MA reported to work at 2:30am; she did not remember who told her. Review of the census and punch cards for staff on 03/24/25 revealed: -There was a census of 41 residents, which required 20 aide hours on second shift. -There was a total of 17 aide hours provided on second shift leaving a shortage of 3 aide hours.	D 194		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 194	Continued From page 67 Review of the census and punch cards for staff on 03/31/25 revealed: -There was a census of 41 residents, which required 20 aide hours on second shift. -There was a total of 14 aide hours provided on second shift leaving a shortage of 6 aide hours. Review of the census and punch cards for staff on 04/24/25 revealed: -There was a census of 39 residents, which required 16 aide hours on third shift. -There was a total of 10 aide hours provided on third shift leaving a shortage of 6 aide hours. Review of the census and punch cards for staff on for 04/25/25 revealed: -There was a census of 38 residents, which required 16 aide hours on second shift. -There was a total of 10.5 aide hours provided on second shift leaving a shortage of 5.5 aide hours. Interview with a PCA on 04/25/25 at 8:22am revealed: -She was working on the AL side of the facility today, 04/25/25. -There was another PCA working with her on the AL side, but she was pulled to the Special Care Unit (SCU), leaving her the only PCA on the AL side with over 30 residents. -Some days they were fully staffed, and other days they were not. -She worked first shift and had come to work several times on the weekends and there would be no MA in the facility. -The third shift MA would not be in the facility; she would leave before the 1st shift MA came in. Interview with a second PCA on 04/29/25 at 12:43pm revealed: -She worked first shift and would stay over a few	D 194		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 194	Continued From page 68	D 194		

hours on second shift when needed.
-The staff rotated from the SCU to the AL on the schedule.
-There was enough staff on first shift, but not always enough staff on second shift.
-When she stayed over and worked second shift, she would help with the residents who were visually impaired because they required more assistance than the other residents.

Interview with a MA on 04/25/25 at 11:00a revealed:
-The facility did not have a full staff on some days.
-Some staff would come in late, call out, or not show up for work.
-The MA for the on-coming shift was usually late, causing her to work over.
-The weekends were short staffed.

Interview with the RCC on 04/29/25 at 11:24am revealed:
-She helped complete the staff schedule.
-There was always enough staff to cover shifts in AL.
-When there were staff callouts, she would contact facility staff to come in or a staffing agency to cover all shifts.
-She would work to cover shifts when there were no staff available to work.

Interview with the Administrator on 04/29/25 at 4:12pm revealed:
-The facility used 3 shifts: 7:00am to 3:00pm, 3:00pm to 11:00pm, and 11:00pm to 7:00am, for aide shifts.
-The RCC was responsible for completing the staff schedule.
-She and the RCC were responsible to ensure the facility had enough staff based on the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 194	Continued From page 69 census each shift. -When shifts could not be covered by facility staff, she would contact the staffing agency to cover staffing in the facility. -She did not know the facility was short aide hours on first shift on 02/14/25 and 03/31/25. -She did not know the facility was short aide hours on second shift on 02/14/25, 03/24/25, and 04/25/25. -She did not know the facility was short aide hours on third shift on 04/24/25. Attempted telephone interview with a previous MA on 04/24/25 at 10:35am was unsuccessful. Attempted telephone interview with the previous RCC on 04/24/25 at 9:28am was unsuccessful. Attempted telephone interview with a third PCA on 04/29/25 at 12:53pm was unsuccessful. Attempted telephone interview with a second MA on 04/29/25 at 2:39pm was unsuccessful. The facility failed to ensure sufficient staffing to meet the needs of the residents in the assisted living to include medication aides, who could not be located in the facility or who were not in the facilty to administer medications as ordered, resulting in a resident who was diagnosed with terminal cancer crying out in pain because he did not receive his pain medication. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/25/25 for this violation. THE CORRECTION DATE FOR THE TYPE B	D 194		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 194	Continued From page 70 VIOLATION SHALL NOT EXCEED JUNE 13, 2025.	D 194		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide personal care assistance for 6 of 10 sampled residents (#4, #10, #11, #12, #14, and #17) including two residents who required assistance with shaving (#11, #12); four residents who required assistance with fingernail care (#10, #11, #12, #17); and two residents whose toenails needed to be cut (#4, #14). The findings are: 1. Review of Resident #14's current FL-2 dated 10/30/24 revealed diagnoses included hypertension, anxiety, blindness in both eyes, coronary artery disease, hyperlipidemia, history carotid stenosis and chronic obstructive pulmonary disease (COPD). Observation of Resident #14 on 04/22/25 at 2:20pm revealed: -She was lying on her bed without shoes or	D 269		

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	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 269	Continued From page 71 socks. -Her toenails were long, thick, and had deep ridges in them. -Her toenails were not evenly cut and were jagged across the top. -There was a pair of open back shoes that could be slipped on by her bed. Review of Resident #14's charting notes from June 2024 to April 2025 revealed there was no documentation regarding Resident #14's toenails, toenail care or contact with a podiatrist. Interview with Resident #14 on 04/22/25 at 2:20pm revealed: -Her big toes hurt because her toenails were too big [long] and broken. -She did not cut her own toenails. -She wished someone would cut her toenails for her. -Her toenails would rub and touch her other foot and would be "aggravating" because it was rough; she did not have scratches or cuts. -She did not say anything to staff about her toenails because they could see them when they gave her a bath. -Staff had cut her toenails the last time they were cut. -She could not recall the last time her toenails were cut, it had been so long. Telephone interview with Resident #14's family member on 04/24/25 at 3:30pm revealed: -She used to cut Resident #14's toenails when she visited but they got too thick for her to cut. -She had not cut Resident #14's toenails in at least a year. -She had let the Administrator know she was not cutting the resident's toenails anymore and they needed cutting.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 269	Continued From page 72 -She thought Resident #14's toenails looked like they were full of dirt and debris and were too long. -Resident #14's toenails had gotten so long they were beginning to break off. Interview with Resident #14's primary care provider (PCP) on 04/29/25 at 12:00pm revealed: -Resident #14's toenails should have been looked at by the facility's staff at least monthly and cut about every two weeks or per policy. -Resident #14 had not complained of pain with her toenails; she had only seen her one time. -Podiatry usually did not see a resident to cut toenails unless they were diabetic or there was something going on with their toenails like they needed debriding. -Long toenails could cause pain when wearing shoes or walking and residents could scratch themselves with long and broken toenails. Interview with a personal care aide (PCA) on 04/25/25 at 10:10am revealed: -She saw Resident #14's toenails and had offered to cut them but she refused. -The PCAs asked her all the time if they could cut her toenails and she said no. -She never asked Resident #14 if they hurt and the resident never complained of pain. Interview with a medication aide (MA) on 04/25/25 at 11:35am revealed: -She reported long toenails to the Resident Care Coordinator (RCC) as she saw them. -She reported Resident #14's long toenails to the RCC last week. -The RCC replied "okay". -Resident #14's toenails had looked like they did for about a year. -Resident #14 did not want anyone to cut her toenails; she refused to let anyone cut her	D 269		

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	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 269	Continued From page 73 toenails. -Resident #14 did not complain of pain and she had not seen cuts or scratches on the resident's legs or feet. Interview with the RCC on 04/29/25 at 11:30am revealed: -She had contacted Resident #14's guardian on 04/24/25 and got consent for her to be seen by the podiatrist. -Resident #14 would be seen by the podiatrist the next time they came to the facility. -She was not sure when the next podiatrist visit was going to be. -After Resident #14 was seen by the podiatrist, the staff should be able to cut her toenails because she was not diabetic. -Resident #14's toenails should not have gotten to the point they were at; the PCAs should have been cutting her toenails at showers and as part of her daily care. -Her toenails were probably not cut because the facility did not have clippers. Interview with the Administrator on 04/29/25 at 4:35pm revealed: -She heard about Resident #14's toenails and knew the RCC had been trying for a couple of weeks to get in touch with the guardian to get consent to schedule a podiatry appointment. -The guardian just called back last week and gave consent for a podiatry appointment. -She had no idea the last time Resident #14 had her toenails cut. -Staff had not reported any complaints of foot pain from Resident #14. Attempted telephone interviews with Resident #14's guardian on 04/24/25 at 2:25pm and 04/29/25 at 8:50am were unsuccessful.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 269	Continued From page 74 2. Review of Resident #4's FL-2 dated 01/28/25 revealed: -Diagnoses included hypertension and dementia with behavioral disturbance. -He needed assistance with bathing, dressing, and feeding; he was total care. Review of Resident #4's care plan dated 01/20/25 revealed he was totally dependent for bathing, dressing, and grooming. Observation of Resident #4's toenails on 04/22/25 at 9:05am revealed: -The skin on top of the resident's feet was dry and flaky. -There was a buildup of dark colored debris and dried skin under and between his toes on the bottom of his left and right foot. -The resident's first toenail on his right foot extended past the end of the toe by ¾ of an inch and was curved toward the second toe. -The second toenail had grown over the end of the toe and was pushed into the bottom of the toe. -The third toenail on the right foot had grown past the end of the toe, and was broken and jagged. -The fourth toe on the right foot had grown over the end of the toe and was pushed into the bottom of the toe. -The toenail on the fifth toe on the right foot had grown over the end of the toe and was pushed into the bottom of the toe. -The resident's first toenail on his left foot extended past the end of the toe by ¼ of an inch. -The second and third toenails extended past the end of the toe by ¼ of an inch. -The fourth toe on the left foot had grown past the end of the toe by 3/4 of an inch and was curved	D 269		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 269	Continued From page 75 toward the third toe. -The toenail on the fifth toe on the left foot was broken. Telephone interview with a representative from the facility's contracted podiatry services on 04/23/25 at 12:53pm revealed Resident #4 was never registered with their office to receive podiatry services. Interview with a personal care aide (PCA) on 04/28/25 at 4:15pm revealed: -She had noticed Resident #4's toenails were long when she assisted the resident with a shower. -She knew the facility did not have any toenail clippers. -She had not told anyone that Resident #4's toenails were long. -She had told a medication aide (MA) one day last week, the week of 04/21/25, that Resident #4's feet looked swollen to her, but she did not know if anyone had looked at his feet. Interview with a MA on 04/24/25 at 8:12am revealed: -She had noticed Resident #4's toenails were long. -She did not know why Resident #4 was not seen by the podiatrist. Interview with a second MA on 04/24/25 at 3:36pm revealed: -She had noticed Resident #4's toenails were long. -Once a month, the facility had a self-care day where the residents were shaved, had their teeth cleaned, and she thought the residents' toenails were also done on that day.	D 269		

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	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 269	Continued From page 76	D 269		

Telephone interview with Resident #4's family member on 04/25/25 at 9:37am revealed:
-She had noticed Resident #4's toenails were long at the end of February 2025.
-Resident #4 could not cut his toenails, and she was not sure whose responsibility it was because his toenails were always long at the previous facility, and when she brought them up, his toenails still did not get cut.
-No one had discussed podiatry services for Resident #4 with her.
-She wanted Resident #4's toenails to be cut.

Interview with the Resident Care Coordinator (RCC) on 04/29/25 at 11:32am revealed:
-On 04/10/25, all residents were seen by the podiatrist.
-She was informed on Thursday, 04/24/25, that there were no clippers in the facility.
-A representative from the podiatrist's office came to the facility and signed everyone up for podiatry services.
-The representative was given the census, and she got copies of every resident's information to get consents signed.
-She did not know Resident #4 was not seen by the podiatrist.

Interview with the Special Care Unit Coordinator (SCC) on 04/25/25 at 10:49am revealed:
-Resident #4 needed assistance with his personal care.
-When the PCAs assisted Resident #4 with washing his feet, she expected to be notified if his toenails were long.
-She was concerned Resident #4's toenails were long because it could cause discomfort to the resident.

Telephone interview with Resident #4's primary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 269	Continued From page 77	D 269		

care provider (PCP) on 04/25/25 at 9:53am revealed:
-She expected Resident #4's toenails to have been trimmed.
-He could potentially develop an infection, experience discomfort, or if the toenails were jagged, he could scratch himself.

Interview with the Administrator on 04/29/25 at 4:53pm revealed:
-She recalled Resident #4 had issues with his feet including having calluses.
-She expected the PCAs and MAs to let the SCC know Resident #4's toenails needed to be trimmed.
-She was concerned that Resident #4's toenails had not been trimmed because it could cause the resident pain.

Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable.

3. Interview with a (PCA) on 04/25/25 at 8:15am revealed:
-PCAs did not shave the residents.
-She was told she could not shave residents; she did not remember who told her.
-She did not feel comfortable shaving the residents.

Interview with a medication aide (MA) on 04/24/25 at 1:20pm revealed:
-The PCAs should shave the residents during the residents' shower.
-There were some PCAs who did not feel comfortable shaving residents.
-There was a male PCA who would shave the male residents if requested.
-There were several MAs who would shave

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	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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(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) COMPLETE DATE
D 269	Continued From page 78	D 269		

residents when requested; she was one of them.
-She did not know of any residents who had requested to be shaved and did not receive assistance.

Interview with the Special Care Coordinator (SCC) on 4/25/25 at 8:35am revealed:
-The PCAs should shave residents on shower days.
-No resident had asked her to shave them.
-The PCAs should document on the personal care service log when residents were shaved.

Interview with the Resident Care Coordinator (RCC) on 04/28/25 at 2:46pm revealed:
-The PCAs should shave residents on their shower days, which was three days a week.
-The PCAs should shave residents daily if the resident requested a daily shave.
-There was one male PCA who assisted with shaving the male residents.
-She did not know there were residents who wanted to be shaved.
-No residents had asked her about wanting to be shaved.
-The PCAs were responsible for shaving the residents.

Interview with the Administrator on 04/29/25 at 3:02pm revealed:
-Residents should be shaved on shower days or when requested.
-The PCAs should shave the residents.
-She expected the PCAs to shave residents three times a week and more often if needed.

a. Review of Resident #11's current FL-2 dated 07/15/2024 revealed:
-Diagnoses included dementia, neurocognitive disorder, and depression.

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	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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) COMPLETE DATE
D 269	Continued From page 79 -The orientation status and the personal care assistance section was blank. Review of Resident #11's previous FL-2 dated 11/13/23 revealed he was constantly disoriented and required assistance with bathing and dressing. Review of Resident #11's signed care plan dated 02/11/25 revealed he required extensive assistance with bathing, grooming, and personal care. Review of Resident #11's personal care service log for April 2025 from 04/01/25 to 04/22/25 revealed: -Resident #11's schedule shower day was Tuesdays, Thursdays, and Saturdays. -There was documentation that Resident #11 was shaved 8 of 10 times from 04/01/25 to 04/22/25. -There was documentation that Resident #11 was shaved on 04/22/25. Observation of Resident #11 on 04/22/25 at 8:35am revealed his beard was ¼ inch long. Observation of Resident #11 on 04/24/25 at 3:28pm revealed: -His beard was 1/4 inch long. -He had not been shaved. Interview with Resident #11 on 04/22/25 at 8:35am revealed: -He wanted to be shaved. -He had asked staff members to shave him, but he always got the same response that they would get back with him. -He did not remember who he had spoken to about shaving him.	D 269		

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	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 269	Continued From page 80 Interview with a personal care aide (PCA) on 04/25/25 at 8:22am revealed: -She shaved residents when they needed to be shaved or when they requested to be shaved. -She had not noticed Resident #11 needed to be shaved. -She did not remember Resident #11 asking her to shave him. b. Review of Resident #12's current FL-2 dated 06/26/24 revealed: -Diagnoses included major neurocognitive disorder and trauma. -He required assistance with bathing. Review of Resident #12's signed care plan dated 07/22/24 revealed: -He required supervision with dressing. -He required limited assistance with bathing, grooming, and hygiene. Review of Resident #12's personal care service log for April 2025 from 04/01/25 to 04/23/25 revealed: -Resident #12's schedule shower day was Mondays, Wednesdays, and Fridays. -There was documentation that Resident #12 was shaved 9 of 10 times from 04/01/25 to 04/23/25. -There was documentation that Resident #12 was shaved on 04/23/25. Observation of Resident #12 on 04/22/25 at 8:42am revealed his beard was ½ inch long. Observation of Resident #12 on 04/24/25 at 3:30pm revealed: -His beard was 1/2 inch long. -He had not been shaved. Interview with Resident #12 on 04/22/25 at	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 269	Continued From page 81 8:41am revealed: -He would like to be shaved and have a clean face. -He could not get anyone to shave him. -He used to ask the staff to shave him, but he had not asked the staff lately, because it was useless. 4. Interview with a personal care aide (PCA) on 04/25/25 at 8:15am revealed: -The PCAs were not allowed to clip fingernails. -No resident had said anything to her about needing their fingernails clipped. Interview with another PCA on 04/25/25 at 8:22am revealed: -No resident had requested to have their fingernails clipped. -She did not know where a fingernail clipper was to clip residents' fingernails, if needed. -She had not noticed any resident's fingernails needing to be clipped. Interview with a medication aide (MA) on 04/24/25 at 1:20pm revealed: -Residents' nails should be cleaned during their shower. -Residents' nails should be clipped when requested or needed. -If the resident was a diabetic, the Registerd Nurse (RN) would clip the residents' fingernails. -She did not know of any residents who had requested to have their nails clipped and did not receive assistance. Interview with another MA on 04/28/25 at 5:15pm revealed: -She did not clip resident fingernails. -She was not responsible for clipping resident's fingernails.	D 269		

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	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 269	Continued From page 82 -No resident had asked her to clip their fingernails. -The PCAs might clip the resident's fingernails, she was not sure who did it. Telephone interview with the facility's primary care provider (PCP) on 04/25/25 at 9:53am revealed unkept nails could potentially develop an infection, discomfort, or if jagged, the resident could scratch themselves. Interview with the Special Care Coordinator (SCC) on 4/25/25 at 8:35am revealed: -The residents' fingernails should be cleaned on shower days. -The residents' fingernails should be clipped when needed. -The resident's fingernails could only be clipped by the MAs, the SCC, or the Resident Care Coordinator (RCC). -No resident had asked her to clip their fingernails. -The PCAs should document on the personal care service log when residents' fingernails were clipped. Interview with the RCC on 04/28/25 at 2:46pm revealed: -No other residents had asked about having their fingernails clipped. -The Owner asked her to go purchase enough supplies so each resident would have their own nail kit on Saturday, 04/26/25. -The PCAs should provide daily fingernail care including clipping the fingernails on non-diabetic residents. -Fingernails should be cleaned and clipped on the resident's shower day. Interview with the Administrator on 04/29/25 at	D 269		

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D 269	Continued From page 83 3:02pm revealed: -The RCC should clip the fingernails of the residents who were diabetic. -The staff should let the RCC know when a residents' fingernails need clipping. -The PCAs should offer to clip the fingernails of residents who were not diabetic, and clean the resident's fingernails while in the shower. -The PCA should document on the ADL form when nail care was performed. -A resident with long, dirty, jagged fingernails could scratch themselves and could lead to infection. a. Review of Resident #10's current FL-2 dated 07/01/24 revealed: -Diagnoses included hypertension, insomnia, morbid obesity and diabetes. -The orientation section and the personal care assistance section was blank. Review of Resident #10's signed care plan dated 04/18/24 revealed he required supervision with grooming and personal hygiene. Review of Resident #10's personal care service log for April 2025 revealed: -He was showered three days a week on Monday, Wednesday, and Friday. -He received nail care 20 of 27 days. Observation of Resident #10's fingernails on 04/28/25 at 4:10pm revealed: -The fingernails on his right hand were ¼ inch long, dirty and jagged. -The 3rd, 4th, and 5th fingernails on his left hand were ¼ inch long and jagged. Interview with Resident #10 on 04/28/25 at 4:10pm revealed:	D 269		

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D 269	Continued From page 84 -His fingernails had not been clipped in a very long time. -He did not know who clipped fingernails. -He had asked different staff over a period of time to clip his nails, but his fingernails never got clipped. -He asked a staff member last week to clip his fingernails, and the staff did not respond. -His fingernails were broken, and he could scratch himself, but he had not scratched himself. b. Review of Resident #12's current FL-2 dated 06/26/24 revealed: -Diagnoses included major neurocognitive disorder and trauma. -He required assistance with bathing. Review of Resident #12's signed care plan dated 07/22/24 revealed: -He required supervision with dressing. -He required limited assistance with bathing, grooming, and hygiene. Review of Resident #12's personal care service log for April 2025 revealed he was provided nail care 9 of 24 opportunities. Observation of Resident #12's fingernails on 04/22/25 at 8:42am revealed: -The fingernails on his right hand were ¼ inch long and the 2nd and 3rd fingernails were jagged. -The fingernails on his left hand were ¼ inch long and were dirty and the 3rd, 4th and 5th fingernails were jagged. Observation of Resident #12's fingernails on 04/24/25 at 3:30pm revealed his fingernails had not been clipped. Interview with Resident #12 on 04/22/25 at	D 269		

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D 269	Continued From page 85 8:42am revealed: -He would like his fingernails clipped; they were broken and dirty. -He could not get anyone to clip his fingernails, so he stopped asking. c. Review of Resident #11's current FL-2 dated 07/15/2024 revealed: -Diagnoses included dementia, neurocognitive disorder, and depression. -The orientation status and the personal care assistance section was blank. Review of Resident #11's previous FL-2 dated 11/13/23 revealed he was constantly disoriented and required assistance with bathing and dressing. Review of Resident #11's signed care plan dated 02/11/25 revealed he required extensive assistance with bathing, grooming, and personal care. Review of Resident #11's personal care service log for April 2025 revealed he was provided nail care 1 of 24 opportunities. Observation of Resident #11's fingernails on 04/22/25 at 8:35am revealed: -The fingernails on his left hand extended ¾ inch past his fingertips with dirt noted under two fingernails. -The fingernails on his right hand extended ½ inch past his fingertips on all of his fingers, except the fifth finger. -The second, third, and fourth fingernails on the right hand were broken and jagged. Observation of Resident #11's fingernails on 04/24/25 at 3:28pm revealed his fingernails had	D 269		

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D 269	Continued From page 86 not been clipped. Interview with Resident #11 on 04/22/25 at 8:35am revealed: -He had asked the staff to cut his fingernails; he did not remember when he asked the staff to cut his nails -He was told the facility did not have any fingernail clippers. d. Review of Resident #17's current FL-2 dated 12/31/24 revealed: -Diagnoses included diabetes, hypertension, limited eyesight, depression, and insomnia. -He was intermittently confused. -He required assistance with bathing and dressing. Review of Resident #17's signed care plan dated 12/31/24 revealed: -He required limited assistance with bathing. -He required extensive assistance with grooming and personal care. Observation of Resident #17's fingernails on 04/25/25 at 2:22pm revealed: -The fingernails on his right hand were ½ inch long, except his thumb nail which was 1 inch long. -The fingernails on his left hand were ½ inch long, except this thumb nail which was 1 inch long. Observation of Resident #17 in the dining room on 04/22/25 at 12:00pm revealed: -Resident #17 was served spaghetti with sauce, broccoli and a frosted brownie at lunch. -He used his fingers to locate his food on his plate. -He used his fingers to assist his food onto his fork and guide his fork to his mouth.	D 269		

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D 269	Continued From page 87 -He licked his fingers while he was eating. Interview with Resident #17 on 04/25/25 at 1:22pm revealed: -He wanted someone to cut his fingernails. -He had asked someone to cut his fingernails, but no one had cut them. -He used his fingers to eat and his nails were too long to pick up the food. Review of Resident #17's personal care service log for April 2025 revealed: -He was showered on Tuesday, Thursday, and Saturday. -He received nail care 23 of 27 days. Interview with Resident #17's primary care provider (PCP) on 04/29/25 at 12:50pm revealed: -She was concerned about his long fingernails because they held bacteria from debris that got caught under them. -Resident #17 used his hands while eating because he was blind and he could get sick from the bacteria under his nails. -The food could also get stuck under his long fingernails and contribute to the bacteria. Interview with Resident #17's family member on 04/29/25 at 10:50am revealed: -Resident #17 had mentioned to her that he needed his fingernails clipped. -Resident #17 said he had mentioned to the staff about clipping his fingernails, but no one had clipped them. -She had mentioned it to the staff recently about getting his fingernails clipped. -She thought someone may have clipped his fingernails on Saturday, 04/26/25. Interview with the Resident Care Coordinator	D 269		

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D 269	Continued From page 88 (RCC) on 04/28/25 at 2:46pm revealed: -She clipped Resident #17's fingernails on 04/26/25 when she was working. -Resident #17 asked her on 04/24/25 to clip his nails, but there were no clippers in the facility. -She asked the personal care aide (PCA) where the fingernail clippers were kept. -The PCAs did not know anything about fingernails clippers being in the facility. -She purchased clippers to clip Resident #17's fingernails. Oberservations of Resident #17's fingernails on 04/28/25 at 4:15pm revealed Resident #17's fingernails had been clipped to the tip of his finger. Interview with the Administrator on 04/29/25 at 3:02pm revealed she asked the RCC to clip Resident #17's fingernails; she was told they were long and dirty. _____ The facility failed to provide personal care assistance, including nail care and shaving, to multiple residents. Residents repeatedly asked staff for assistance with personal care needs, but received no response, resulting in residents no longer asking for assistance. This failure resulted in a resident experiencing pain because her toenails were long and jagged (#14), two residents, who were diabetic having fingernails which were long, broken, and dirty (#10, #17), and a resident (#17), who used his fingers to eat having nails one inch to a half inch long. This failure resulted in neglect of the residents, which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/26/25.	D 269		

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D 269	Continued From page 89 THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MAY 29, 2025.	D 269		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the health care needs for 7 of 8 sampled residents (#1, #2, #3, #4, #14, #15, #21) related to a resident having a change in her behaviors (#1), an appointment for a consultation related to a cancer diagnosis (#2), a referral for physical therapy (#3), a referral for a urologist and physical and occupational therapy (#4), multiple appointments for further testing related to a cancer diagnosis (#14), a referral for speech therapy for a swallowing evaluation (#15), and refusals of medication and a change in behaviors (#21). The findings are: 1. Review of Resident #14's current FL-2 dated 10/30/24 revealed diagnoses included hypertension, anxiety, blindness in both eyes, coronary artery disease, hyperlipidemia, history carotid stenosis and chronic obstructive pulmonary disease (COPD).	D 273		

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D 273	Continued From page 90	D 273		

Review of Resident #14's after visit report from the mental health provider (MHP) dated 03/19/25 revealed her cognition was forgetful.

Review of Resident #14's hospital surgical pathology report dated 12/17/24 revealed:
-Resident #14 had a distal rectum biopsy completed on 12/13/24.
-The biopsy results included squamous cell carcinoma (SCC). (squamous cells that are classified as high-risk, aggressive cancers) and immunohistochemical stain as positive in the tumor (staining can provide additional information about the condition being assessed).

Review of Resident #14's after visit report from a local cancer treatment center dated 02/28/25 revealed:
-She was referred to the cancer center by a gastroenterologist and a surgeon due to squamous cell carcinoma involving the anal verge extending into the distal rectum.
-Resident #14 was documented as having mild hearing loss, legal blindness, confusion and cognitive impairment.
-On 10/24/24, she was seen at the local emergency department (ED) for rectal pain and bleeding that had worsened over two weeks.
-A Computed Tomography (CT) scan showed thickening and hyperenhancement (swelling or thickening) on the anorectal junction as well as the anal canal.
-On 12/13/24, she was seen by a gastroenterologist for a digital rectal exam (DRE) and a biopsy was performed which returned with poorly differentiated SCC and malignant cells.
-On 02/28/25, Resident #14 was referred to an imaging center for a Positron Emission Tomography (PET) scan and pelvic Magnetic Resonance Imaging (MRI) the following week (no

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D 273	Continued From page 91	D 273		

dates documented) for staging.
-Resident #14 had anal carcinoma which had advanced to the perianal skin and distal rectum.

Review of Resident #14's scheduled appointments from the PET scan imagining center revealed:
-She was scheduled for a PET scan on 03/03/25 at 6:45pm, 03/17/25 at 6:45pm, 03/31/25 at 5:45, and 04/28/25 at 3:15pm.
-There was documentation the imaging center contacted the facility before each appointment.
-There was electronic communication between a representative from the cancer center and a representative from the imaging center on 02/28/25.
-The cancer center sent the imaging center an order for the PET scan on 02/28/25.
-The imaging center confirmed with the cancer center that a PET scan was scheduled for Resident #14 on 03/03/25 at 6:45pm.
-The imaging center confirmed Resident #14's PET scan appointment with the facility on 02/28/25.

Review of Resident #14's progress notes from 01/01/25 to 04/29/25 revealed:
-On 04/18/25, The facility staff received a call from the cancer center to reschedule a PET scan appointment for 04/29/25 in the evening, no time was documented.
-Resident #14 was to be nothing by mouth (NPO) 6 hours prior to the procedure [scan].

Review of Resident #14's rescheduled PET scan appointment reminder revealed:
-The PET scan reminder was from the Registered Technologist at the imaging center and was not dated.
-Due to equipment issues at the imaging center

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D 273	Continued From page 92	D 273		

Resident #14's PET scan appointment for 04/14/25 was cancelled by the imaging center and rescheduled.
-The PET scan was rescheduled for 04/28/25 at 3:15pm.
-Resident #14 could not be administered diabetic medications for six hours prior to the PET scan.
-She could not eat anything for six hours prior to the PET scan but could have water up until the injection of the isotope dose.

Review of the facility's appointment calendar for February 2025 revealed:
-On 02/04/25, Resident #14 had an appointment at 10:00am; there was an address and no other information.
-On 02/05/25, Resident #14's name, 2:30pm and called to reschedule were written on the calendar; there was no other information documented.
-On 02/13/25, Resident #14 had an appointment at 10:00am at the same address documented on 02/04/25.
-On 02/28/25, Resident #14 had an appointment at 11:00am at the cancer center.

Review of the facility's appointment calendar for March 2025 revealed:
-On 03/03/25, Resident #14 had an appointment at 6:45pm for radiology.
-On 03/10/25, Resident #14 had an appointment, but the time and place were not legible.
-On 03/17/25, Resident #14 had an appointment for a PET scan at 6:45pm with NPO for 6 hours before [the scan] starting at 12:45pm.
-On 03/20/25, Resident #14 had an appointment for an MRI at 7:20am and an appointment at the cancer center at 2:00pm.
-On 03/21/25, Resident #14 had an appointment at 12:00pm at the local women's health center.
-On 03/31/25, Resident #14 had an appointment

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D 273	Continued From page 93 for a PET scan at 5:45pm and NPO 6 hours prior to the appointment. Review of the facility's appointment calendar for April 2025 revealed: -On 04/02/25, Resident #14 was scheduled for an appointment at the cancer center at 10:00am. -There was a note that the appointment would be rescheduled by the cancer center once Resident #14's PET scan was rescheduled. -On 04/14/25, Resident #14 was scheduled for a PET scan at 3:00pm and was NPO for 6 hours. -There was a sticky note with Resident #14's name, a phone number, and 03/21/25 at 12:00pm handwritten on it. -There was nothing on the appointment calendar for Resident #14 on 04/28/25. -On 04/29/25, Resident #14 was scheduled for an appointment at the cancer center at 8:00am. Interview with Resident #14 on 04/25/25 at 11:25am revealed: -She did not know about a PET scan or recall having an MRI done. -She was never told not to eat or drink anything because she was having a test. -She did not recall discussing her bowel movements with anyone. -She had not gone to a medical specialist for anything. -She had not gone to a medical building for an appointment with a specialist or for a PET scan or MRI. -She did not have any pain in her stomach or when she had a bowel movement. Interview with Resident #14 on 04/28/25 at 8:50am revealed: -She did not have any appointments, and no test scheduled for the day.	D 273		

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ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 273	Continued From page 94 -She had not been instructed not to eat anything. Interview with Resident #14 on 04/29/25 at 7:50am revealed: -She had not eaten breakfast yet. -She had not been told not to eat breakfast. -She was not going anywhere today, 04/29/25. Observation of Resident #14 on 04/29/25 at 8:00am revealed: -She was seated at a table in the dining room. -She was served breakfast and beverages. Telephone interview with one of Resident #14's family members on 04/24/25 at 3:00pm revealed: -She was diagnosed with rectal cancer in October 2024. -She was concerned Resident #14 was not getting additional testing and not being treated for the cancer. -She had asked the facility about Resident #14's cancer treatments, but they would not talk to her about the resident's medical treatments. -Resident #14 did not remember anything about any medical test or cancer treatments because she had vascular dementia. -She felt like the facility was "waiting for her [Resident #14] to die". Telephone interview with a second family member on 04/24/25 at 3:30pm revealed: -Resident #14 had rectal cancer for about six months. -Staff told her Resident #14 did not go for a procedure because she ate before the procedure when she was not supposed to. -Resident #14 could not remember things and could not tell her about her appointments. -She did not know much about her treatments because the facility would not share Resident	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 273	Continued From page 95	D 273		

#14's medical information.
-She was concerned Resident #14 was not getting the [medical] care she needed.

Telephone interview with a representative from the scheduling department at the PET scan imaging center on 04/25/25 at 9:30am revealed:
-PET scan imaging was only done on Mondays beginning at 2:30pm.
-He could not see past appointments.
-Resident #14 was scheduled for a PET scan on 04/28/25 at 3:15pm.

Telephone interview with a representative from the scheduling department at the cancer center on 04/25/25 at 9:45am revealed:
-Resident #14 was referred to the cancer center for treatment by her gastroenterologist in January 2025.
-Her first appointment with the center's oncologist was 02/28/25; she went to the appointment.
-She was scheduled for an appointment on 04/02/25 but was a no call and no show.
-She had an upcoming appointment scheduled for 04/29/25.

Interview with Resident #14's primary care provider (PCP) on 04/29/25 at 12:00pm revealed:
-She had only seen paperwork on Resident #14's initial diagnosis of cancer.
-She should have chemotherapy treatment for her cancer.
-She was not aware Resident #14 was missing appointments related to her cancer.
-Resident #14 could not remember to not eat or drink due to her cognition.
-The facility should have staff sit with her to ensure she remained NPO before a procedure.

Telephone interview with a Registered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 96 Technologist from the imaging center on 04/29/25 at 9:05am revealed: -Resident #14 had a scheduled appointment for a PET scan on 04/28/25 at 3:15pm but she did not call to cancel and did not show up for the scan. -She called the facility on Friday, 04/25/25 to confirm the appointment for the PET scan on 04/28/25. -She reminded the staff over the phone Resident #14 needed to be NPO and no diabetic medication for 6 hours prior to the scan; she could have some water. -PET scan appointments were only made every other Monday. -The imaging center contacted the cancer center when the PET scan was scheduled so they could schedule an appointment with the resident. -Resident #14 had missed multiple appointments for PET scans and she had also missed MRIs at the imaging center on 12/16/24 and 03/20/25; she did not call or show up for the appointments. -PET scans were typically ordered after an MRI was completed. -If there was something seen on the MRI then the PET scan would be ordered to show if the cancer had spread to other organs in the body. -She had attempted to reach the Registered Nurse [Resident Care Coordinator (RCC)] at the facility multiple times to discuss the importance of getting Resident #14 to the PET scan. -Resident #14 was brought to an appointment and the personal care aide (PCA) told her the resident had eaten so they could not perform the PET scan. -The facility was responsible for ensuring Resident #14 was NPO prior to the PET scan. -She always called the facility before the appointments to confirm the date and time. -She had even written a letter to the facility with the appointment date, time and the NPO	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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) COMPLETE DATE
D 273	Continued From page 97	D 273		

instructions for the PET scan scheduled for 04/28/25.
-She always reached out to the facility to reschedule Resident #14's missed appointments; she would have to call the facility multiple times to reach staff.
-The oncologist at the cancer center could not move forward with Resident #14's cancer treatments because the PET scan was needed for diagnosing what stage the cancer was in.
-The imaging center had a rule about missed appointments; after the fourth missed appointment they would not reschedule a scan.
-Resident #14 would be rescheduled one more time for a PET scan but could not miss it.

Telephone interview with the clinical nurse at the cancer center on 04/29/25 at 9:01am revealed:
-Resident #14 had an appointment for 8:00am that morning and did not call or show up for the appointment.
-She spoke to someone at the facility yesterday afternoon, 04/28/25 and confirmed the appointment for 04/29/25 at 8:00am.
-She also confirmed Resident #14 had transportation and a PCA to come with her to the appointment scheduled on 04/29/25.
-She had not received a call from the facility to reschedule the missed appointment for today.
-Resident #14 had follow-up appointments scheduled after her scheduled PET scans so the oncologist could review the scan; she had missed every one of the appointments at the oncologist.
-Resident #14's cancer could not be staged because she had not had a PET scan yet.
-She called the facility to confirm the appointments, and she contacted the facility to reschedule appointments every time Resident #14 missed one.
-Missing appointments was holding Resident #14

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	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 98 back from her treatment. Interview with the Kitchen Manager on 04/29/25 at 8:01am revealed: -The RCC told her when a resident was NPO and she made a sign and posted it on the food serving line in the kitchen. -She was not told that any of the residents were NPO for today, 04/29/25. Interview with a PCA on 04/25/25 at 10:10am revealed: -The medication aide (MA) would tell her in the morning when a resident was NPO. -Resident #14 had been NPO before, staff would tell her, and she would forget and eat or drink, or she got hungry and would eat. -She could get snacks or drinks from other residents. Interview with another PCA on 04/29/25 at 8:00am revealed: -She was not told Resident #14 was NPO. -She was not told Resident #14 was going anywhere today, 04/29/25. Interview with a MA on 04/25/25 at 11:35am revealed: -She was not told about any appointments for residents. -The PCAs were told about appointments for residents so they could get them ready to go out. Interview with another MA on 04/29/25 at 8:04am revealed: -Resident #14 was not NPO and she was not scheduled to go out for an appointment today, 04/29/25. -She was going to check with the transporter about the appointment.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 273	Continued From page 99 Interview with the Activity Director on 04/29/25 at 8:05am revealed: -The Administrator asked her around 7:15am or 7:30am that morning, 04/29/25 to reschedule Resident #14's appointment because the resident had eaten breakfast and was not NPO. -The Administrator told her to reschedule Resident #14's physicians' appointment from 8:00am to later today, 04/29/25. -She had left a message with the physician. -Resident #14 was scheduled for her first PET scan or a follow-up; she was not sure and was waiting for the physician to call her back. Interview with the facility's transportation staff on 04/28/25 at 5:55pm revealed: -The RCC scheduled the residents' appointments. -The RCC let her know when and where the appointment was and she transported the residents. -She took the electronic medication administration record (eMAR) and a copy of the FL-2 to each appointment. -The physician's office would give her the information from the appointment and she would give it to the RCC when she returned to the facility. -The RCC verified appointments for the residents. -Resident #14 had an appointment for a PET scan on 04/29/25 at 8:30am. Interview with the facility's transportation staff on 04/29/25 at 11:10am revealed: -She did not know Resident #14 had an appointment for a PET scan on 04/28/25. -She gave the RCC all the paperwork from the appointment on 04/17/25 when the imaging center did not have contrast.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 273	Continued From page 100 -She was told the appointment for today, 04/29/25, was cancelled because Resident #14 was supposed to be NPO and she ate breakfast. -She did not know anything about missing keys to the van. -She had asked if she could help keep appointments in the calendar, but she was told the RCC could only do them. Interview with the RCC 04/24/25 at 4:58pm revealed: -Resident #14 was waiting for a PET scan. -Resident #14 was supposed to be NPO for six hours prior to the PET scan. -She had been scheduled for PET scans but had to cancel multiple times because she would always eat or drink. -They had tried to keep Resident #14 NPO, but she would eat or drink something; Resident #14 would say she forgot. -She told the staff and Resident #14 when the resident was NPO and Resident #14 would forget and still eat. -They had tried everything to keep Resident #14 NPO including verbally telling all staff she was NPO and putting a sign on her door, but she always ate or drank. -The PET scan imaging only scheduled appointments after 3:00pm so it was hard to keep Resident #14 NPO. -The last PET scan appointment had to be cancelled because Resident #14 drank water from the sink in her room with a medication cup. -On 04/14/25, staff took Resident #14 to the imaging center for her PET scan; she drank some sips of water, but they took her anyway. -The PET scan was cancelled by the imaging center because they did not have the contrast for the scan. -The imaging center rescheduled her for another	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 273	Continued From page 101 PET scan for 04/29/25 at 8:00pm; she thought it was the fourth scheduled PET scan. -On 04/02/25, the nurse from the cancer center told her they could not see Resident #14 until the PET scan was done. -The oncologist at the cancer center could not begin cancer treatments for Resident #14 until the PET scan was completed. -She had not contacted the cancer center concerning any more of Resident #14's appointments. -Resident #14 missed about four PET scans since she began working at the facility. -She spoke to the nurse at the imaging center who said Resident #14 had missed about seven appointments for imaging. -She was concerned the cancer was "liable to have spread by now". Interview with the RCC on 04/28/25 at 8:55am revealed Resident #14 had a PET scan scheduled at 8:00pm the next day, 04/29/25. Interview with the Administrator on 04/29/25 at 10:10am revealed: -Resident #14 was diagnosed with cancer before she became the Administrator in March 2025. -Resident #14 missed her appointment this morning, 04/29/25, because the van keys were not in their normal place. -She was not sure where or what Resident #14's appointment today was for. -She asked the Activity Director to call and reschedule the appointment for later today; she did not know if it had been rescheduled. -Resident #14 did not have a PET scan scheduled yesterday, 04/28/25. -She documented missed appointments in the resident's record. -She was not aware of missed MRI	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 273	Continued From page 102	D 273		

appointments; it was before she began working at the facility.
-She was not aware Resident #14 had missed multiple PET scan appointments and missed oncology appointments.
-She did not realize Resident #14 also had missed oncologist appointments at the cancer center that were scheduled the day after she was supposed to have a PET scan.
-She was only aware of the two missed PET scans.
-The first PET scan was missed because the resident was NPO and drank water, so they called the imaging center and cancelled; the second PET scan was cancelled by the imaging center because they did not have the contrast.
-PET scans were used for cancer diagnosing.
-PET scans were scheduled later in the day.
-She did not know that if Resident #14 missed one more PET scan appointment the imaging center would not schedule her for any more appointments.
-The RCC and the transportation staff were responsible for the appointment calendar and worked on it together.
-The RCC was responsible for scheduling PET scan appointments and for ensuring the resident was NPO before the appointment.
-The RCC was responsible for informing the PCAs and the MAs that Resident #14 was NPO.
-The PCAs and MAs were responsible for making sure Resident #14 did not eat or drink if she was NPO.
-Resident #14 should have been assigned a PCA to have one on one to ensure she did not eat or drink if she could not remember herself.
-The facility was responsible for getting residents to their appointments.
-Resident #14's missed appointments were a huge concern to her because the resident had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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) COMPLETE DATE
D 273	Continued From page 103	D 273		

cancer and appointments should have been treated as urgent because now the resident's care was delayed.
-The facility only had one transportation staff to transport residents to their appointments.
-The transportation staff went with the residents to their appointments and received after visit reports and appointment schedules if the resident did not understand.
-If the appointment was on their appointment calendar, then the resident went to the appointment.
-It was the facility's responsibility to get residents to their appointments but only if they knew about them.
-When there were multiple appointments on the same day or at the same time the transportation staff would take a PCA with them and drop the PCA and the resident off at the appointment together.
-The facility tried not to schedule appointments together.
-Referrals were usually scheduled by the physician and the office would give the facility the date and time.
-When there was a conflict for scheduled appointments, they would reach out to families to help get residents to appointments.

Attempted telephone interviews with Resident #14's guardian on 04/24/25 at 2:25pm and 04/29/25 at 8:50am were unsuccessful.

2. Review of Resident #2's current FL-2 dated 01/28/25 revealed diagnoses included dysphagia, chronic pain, hyperlipidemia, anxiety, muscle weakness, edema, and chronic obstructive pulmonary disease (COPD).

Review of Resident #2's progress notes from the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 273	Continued From page 104 Veterans Administration (VA) hospital dated 03/02/25 revealed: -Resident #2 was transferred to a local hospital for a fall; no dates were given. -She was transferred to the VA hospital on 02/28/25 after the local hospital completed a Computed Tomography (CT) scan. -The CT scan of her abdomen showed she had enlarged lymph nodes in her abdomen and pelvis. -The VA hospital repeated the CT scan and did a Positron Emission Tomography (PET) scan which showed the lymph nodes were hyperactive, increasing the concern that they were cancerous. -A biopsy was also conducted while she was in the hospital due to the concern that the resident might have lymphoma (cancer of the lymphatic system). -A repeat scan of her chest was completed which showed some small nodules that needed to be followed up with a repeat scan to be ordered and scheduled around May 2025. -The VA was going to reach out to schedule "appropriate follow-up" appointments. -She was discharged from the VA hospital on 03/03/25. Review of Resident #2's appointment reminder dated 03/03/25 revealed: -She was scheduled for an appointment with a hematologist from the VA on 03/27/25 at 11:15am. -She was to report to the hematology lab. -After the lab work was completed, she was to report to the assigned provider. -She was to arrive 30 minutes before the scheduled appointment time and bring a list of medications she was currently taking. Review of Resident #2's letter from the VA dated	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 105 03/28/25 revealed: -She was scheduled for an appointment with a hematologist from the VA on 04/10/25 at 10:45am. -She was to report to the hematology lab. -After the lab work was completed, she was to report to the assigned provider. -She was to arrive 30 minutes before the scheduled appointment time and bring a list of medications she was currently taking. Review of Resident #2's progress notes from 01/23/25 to 04/22/25 revealed: -There was no documentation about her diagnosis of hyperactive lymph nodes or possible cancer. -There was no documentation for her appointments with the hematologist at the VA. Review of the facility's appointment calendar for March 2025 revealed Resident #2 did not have any appointments on the schedule. Review of the facility's appointment calendar for April 2025 revealed: -On 04/01/25, Resident #2 was scheduled for an appointment at 12:30pm at the VA. -On 04/10/25, Resident #2 was scheduled for an appointment at 10:45am at the VA. -The address for the appointment was documented on the date box for 04/10/25. -There was a bracket drawn out to the right side of the appointment with the word "telemed" written beside the bracket. -Resident #2 had an appointment on 04/17/25 at 10:45am at the local hospital. -There were lines drawn through the appointment information and a large arrow drawn from the 04/17/25 calendar box to the 04/10/25 calendar box.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 106 -There was an appointment with radiology at the VA on 04/28/25 at 1:00pm; Resident #2's name was not on the appointment. -She was nothing by mouth (NPO) beginning at 7:00am on 04/28/25. -She did not have any other appointments documented in the appointment calendar for April 2025. Interview with Resident #2 on 04/23/25 at 10:50am revealed: -She had missed appointments at the VA hospital; some of the appointments were related to her cancer treatments. -She was diagnosed with lymphoma while in the hospital in February 2025. -She thought she was supposed to have chemotherapy by now, but the facility did not get her to her scheduled appointments at the VA. -The VA scheduled her appointments. -She did not call the VA to schedule or change her appointments. -The VA sent her a virtual voicemail reminder to her personal cell phone for her scheduled appointments. -The VA sent letters with the scheduled appointments on them; the Administrator got the letters. -She did not have the in-person consult with her hematologist when it was scheduled on 04/10/25. -She had gotten to an appointment late on 04/17/25 and had missed other dates. -She was worried about missing appointments and having a delay in her chemotherapy. Telephone interview with a representative from the scheduling department at the VA on 04/23/25 at 11:25am revealed: -He could not go back and look at appointments from previous months.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 273	Continued From page 107 -On 04/10/25, Resident #2 had an appointment with the hematologist that was done by telephone. -On 04/17/25, Resident #2 had an appointment with the hematologist that was done in-person. -Resident #2 had an upcoming appointment scheduled with the VA primary care provider (PCP) on 04/29/25 at 1:00pm. Telephone interview with a Registered Nurse from the VA on 04/25/25 at 2:35am revealed: -On 04/07/25, Resident #2 was a no show for an appointment at the VA. -The VA called the facility on 04/07/25 at 10:20am and they were told the resident did not have transportation to the appointment. -Resident #2 was rescheduled for an in-person appointment for lab work on 04/10/25. -The facility contacted the VA on 04/10/25 and requested the appointment be done via telephone because they did not have transportation for Resident #2; the consultation was done on the telephone. -Resident #2 was rescheduled for an in-person appointment for lab work on 04/17/25. -The VA inquired about transportation arrangements when the appointment was rescheduled and were assured by the facility that Resident #2 had transportation for the 04/17/25 appointment. -On 04/17/25, Resident #2 arrived 90 minutes late by private care for her appointment due to transportation issues. -The staff who accompanied Resident #2 to the appointment did not have a list of her medications. -The VA always requested a list of current medications for appointments. -Getting her to her scheduled appointments was pertinent for treatment for her cancer.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 273	Continued From page 108 -Resident #2's lymphoma was stage three, was aggressive and would continue to grow without treatment. -She needed intensive treatments and missed appointments could be detrimental because she was not getting treatment timely. Interview with a Registered Nurse from Resident #2's PCP at the VA on 04/29/25 at 9:40am revealed: -Resident #2's appointments with the VA were scheduled while she was at a current appointment; before she left the office. -Resident #2 was given a sheet at the checkout with all appointment dates and times with any discipline scheduled anywhere within the VA. -The VA also followed up with telephone calls to confirm the appointment; Resident #2 had difficulty hearing so she was also sent a visual telephone message to confirm appointments to the resident's cell phone. -Resident #2 had missed an appointment on 03/18/25 because she did not have transportation. -Resident #2 had an appointment at the VA today, 04/29/25 at 1:00pm for a follow-up and drug reconciliation with her PCP. -Resident #2 was scheduled at the VA for an injection for her cancer treatment on 05/08/25. Interview with the transportation staff at the facility on 04/28/25 at 5:55pm revealed: -The Resident Care Coordinator (RCC) scheduled the residents' appointments. -The RCC let her know when and where the appointment was and she transported the residents. -She had transported Resident #2 to her appointments at the VA. -She was a little late for one appointment	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 273	Continued From page 109	D 273		

because no one told her she had to take the resident to the VA until that morning.
-She took a copy of the electronic medication administration record (eMAR) and a copy of the FL-2 to each appointment.
-The physician's office would give her the information from the appointment and she would give it to the RCC when she returned to the facility.
-The RCC verified appointments for the residents.

Interview with the facility's transportation staff on 04/29/25 at 11:10am revealed:
-Resident #2 had told her yesterday, 04/28/25, she had an appointment for today at 1:00pm at the VA.
-She did not know if the appointment for today was on the calendar; she told the RCC this morning she was taking Resident #2 to her appointment.
-Sometimes she would get paperwork at the VA and sometimes she would not.
-She was not aware the VA could print her out a copy of all VA scheduled appointments.
-The VA usually called the facility and confirmed the appointments.

Interview with the RCC on 04/24/25 at 3:50pm revealed:
-Resident #2 returned from a hospital stay on 03/04/25.
-She was diagnosed with lymphoma while in the hospital.
-She had not been seen for her lymphoma since she returned from the hospital.
-Resident #2 had a test for her lymphoma while in the hospital.
-The VA physicians called Resident #2 on her personal telephone to schedule appointments.
-She spoke with Resident #2's oncologist in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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) COMPLETE DATE
D 273	Continued From page 110	D 273		

middle of March 2025 about an appointment scheduled on 03/27/25 for further testing.
-The VA sent Resident #2 a letter in the mail about the appointment; it was scheduled for 03/27/25 at 11:15am at the VA.
-The Administrator opened the letter, but it came after the appointment date.
-The VA called Resident #2 and the facility on 03/27/25 to let them know the results from the biopsy that was done while Resident #2 was in the VA hospital were not ready.
-The VA cancelled the appointment scheduled for 03/27/25 on 03/27/25 because they did not have the biopsy results.
-Resident #2 would call the VA herself and schedule appointments and when she would tell the facility about the appointment it would conflict with another appointment already on the schedule.
-Resident #2 thought the facility could not take her to her appointments at the VA.
-Resident #2 had an appointment on the schedule for 04/01/25 at 12:30pm at the VA; there was no reason documented for the appointment or the physician's name on the schedule.
-She did not think Resident #2 went to the appointment on 04/01/25.
-On 04/10/25 at 10:45am, Resident #2 made a tele-a-med call with a VA physician; the RCC and the Administrator were in the office during the call.
-The appointment was to inform Resident #2 she had lymphoma and to discuss her treatment plan.
-The plan was for three weeks on chemotherapy and three weeks off chemotherapy at a local hospital.
-The VA scheduled an in-person appointment on 04/17/25 at 10:45am for a consultation with Resident #2, but they did not know about the appointment until that morning when Resident #2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 111 told them. -After her appointment on 04/17/25, the VA physician scheduled an appointment on 05/01/25 for a consultation at the local hospital. -Resident #2 requested to go to the VA hospital for her treatment but the physician at the VA advised her to go to the local hospital due to the distance to the VA. -Resident #2 called the VA on 04/21/25 to schedule treatment but she was told she needed to have an appointment to have a port placed. -Resident #2 began to come to the RCC's office to schedule her appointments; she was not sure when she began to do this. -The facility would provide transportation for Resident #2 to her appointments at the VA. -Resident #2 had a scheduled appointment for 04/28/25 at 1:00pm at the VA for her port placement. -Resident #2 told the facility she wanted to cancel the appointment scheduled for 05/01/25 at the local hospital because she wanted to go to the VA for her treatments. -Resident #2 told her she had a scheduled appointment on 04/29/25 with her PCP at the VA. -She did not know about any appointments scheduled after the port placement on 04/28/25. -She thought Resident #2 was on her telephone yesterday, 04/23/25, with the VA changing appointments. -Any delays in scheduling appointments for Resident #2 were due to the VA not being able to determine what her diagnosis was because they were waiting for the biopsy results from the hospital. Interview with the Administrator on 04/29/25 at 10:00am revealed: -She did not know about today's, 04/29/25, appointment until about 7:45am.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 273	Continued From page 112 -Resident #2 came to her and showed her an appointment for today, 04/29/25, on her telephone. -Resident #2 told the transportation staff yesterday, 04/28/25 about her appointment today. -Resident #2 made appointments with the VA on her own and she had been told she could not do that. -Resident #2 kept the after-visit summary reports from the VA and did not give them to her. -Resident #2 had not missed any appointments at the VA. -Resident #2 had an appointment where she called the PCP, and the PCP called the resident back and did a tele-a-health visit. -She did the tele-a-health visit because her results from her pathology appointment were not back yet so there was no need for an in-person visit. -The facility did not get confirmations of appointments; the resident got them on her telephone. -The VA sent Resident #2 a schedule of appointments in the mail; they gave the resident her mail and then she would give the appointment schedule to them. -It was up to the resident to tell them about any scheduled appointments. -The RCC called the PCP at the VA and requested for them to contact the facility for appointments, not just the resident. -She did not recall when the RCC reached out to the VA. -The facility only had one transportation staff to transport residents to their appointments. -The transportation staff went with the residents to their appointments and got after visit reports and appointment schedules if the resident did not understand. -She was not aware of any missed appointments	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 113	D 273		

for Resident #2.
-If the appointment was on their appointment calendar, then the resident went to the appointment.
-It was the facility's responsibility to get residents to their appointments but only if they knew about them.
-When there were multiple appointments on the same day or at the same time the transportation staff would take a personal care aide (PCA) with them and drop the PCA and the resident off at the appointment together.
-The facility tried not to schedule appointments together.
-Referrals were usually scheduled by the physician and the office would give the facility the date and time.
-When there was a conflict for scheduled appointments they would reach out to families to help get residents to appointments.

3. Review of Resident #15's current FL-2 dated 10/30/24 revealed diagnoses included type II diabetes mellitus, chronic kidney disease stage 3, and hyperlipidemia.

Review of Resident #15's after visit notes from his primary care provider (PCP) dated 10/09/24 revealed:
-Resident #15's main complaint was choking while eating.
-Staff had reported observing the resident choking and even vomiting after eating.
-Resident #15 had a referral for a swallow study by speech therapy for swallowing issues.

Review of Resident #15's after visit notes from his PCP dated 10/30/24 revealed:
-Resident #15 was seen by the PCP for ongoing issues with oral intake of food and liquid resulting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 273	Continued From page 114	D 273		

in difficulty with swallowing and active vomiting.
-Resident #15 had not yet been seen for a swallow study with a speech pathologist.
-The PCP was told by the facility staff they were working on transferring the resident to a skilled care facility for potential tube feed placement due to the difficulties with intake.

Review of Resident #15's after visit notes from his PCP dated 01/29/25 revealed Resident #15 had continued oral intake issues due to possible esophageal stricture (narrowing of the esophagus making swallowing difficult).

Review of Resident #15's record revealed there was no documentation of an appointment or a completed evaluation for swallowing by a speech therapist.

Review of the facility's appointment calendar for April 2025 and May 2025 revealed Resident #15 was not scheduled for a swallow evaluation with a speech therapist.

Interview with Resident #15 on 04/24/25 at 12:25pm revealed:
-He had trouble with swallowing since he had radiation treatment on his throat for cancer three years ago.
-He had not had a swallow test with the speech therapist since he was admitted to the facility two years and nine months ago.
-He usually coughed while eating and drinking and he choked too.
-He had no idea how often he coughed; it was not a lot.
-He had thrown up while eating but he could not remember how recently it had been.
-He had not been to the hospital after he threw up while eating.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 115 -He wanted to see a speech therapist for a swallowing test to see if he could be removed from the pureed diet and thickened liquids. Interview with Resident #15's PCP on 04/29/25 at 12:00pm revealed: -She had written a referral for Resident #15 to speech therapy for a swallow evaluation due to issues with swallowing. -She did a triage note and put the referral in her after visit report on 04/01/25. -The facility had access to the after visit report and could print them off to review and place in the resident's record. -She had not been told Resident #15 had vomited while eating and drinking. -If he was vomiting then he was aspirating. -She expected the facility to schedule the referral for speech the day after the referral was written. -She was concerned the appointment had not been scheduled because Resident #15 was coughing and vomiting. Interview with a personal care aide (PCA) on 04/24/25 at 9:35am revealed: -She had heard Resident #15 cough while eating and drinking. -She had observed Resident #15 clearing his throat while eating in the dining room. -When he cleared his throat, it was long, deep and loud. -Resident #15 had thrown up in the dining room while eating. -Resident #15 vomited the week before; he would drink something after eating and then throw up. Interview with the Resident Care Coordinator (RCC) on 04/29/25 at 3:30pm revealed: -She was responsible for scheduling appointments for residents when the PCP wrote a	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 273	Continued From page 116	D 273		

referral.
-It depended on when she received the referral from the PCP, but she scheduled appointments as soon as she received referrals.
-She had asked a home health agency about speech therapy evaluations when another resident had a referral, but she was told they did not have a speech therapist.
-The week after the PCP ordered the referral for Resident #15, she asked the PCP where to find a speech therapist; the PCP was going to tell her where to send him.
-She had not followed-up with the PCP since; it had slipped her mind.
-She did not know where to send Resident #15 for a speech evaluation.
-The referral was written on 04/01/25; it had been 28 days since the referral, and she realized it should have been scheduled sooner.

Interview with the Administrator on 04/28/25 at 4:55pm revealed:
-Staff had not reported Resident #15 coughing or vomiting at meals.
-If staff had reported the coughing or vomiting to her, she would have gotten a referral from the PCP for a speech consultation.
-She was concerned because if Resident #15 was vomiting, that was from aspirating.

Interview with the Administrator on 04/29/25 at 3:21pm revealed:
-She was not aware Resident #15 had a referral for speech therapy for a swallow evaluation dated 04/01/25.
-The RCC was responsible for scheduling any appointments including referrals.
-It had been four weeks since the referral, an appointment should have been scheduled by now.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 273	Continued From page 117 -A swallow evaluation would help explain why Resident #15 was choking while eating and drinking. 4. Review of Resident #21's current FL2 dated 02/04/25 revealed -Diagnoses included schizophrenia and dementia. -He was intermittently disoriented. -He wandered. a. Review of Resident #21's FL-2 dated 02/04/25 revealed an order for aripiprazole (used to treat schizophrenia to regulate mood, behaviors, and thoughts) 5mg take one tablet daily. Review of Resident #21's electronic medication administration (eMAR) records revealed: -There was an entry for aripiprazole 5mg once daily with a scheduled administration time of 8:00am. -In January 2025, there was documentation Resident #21 refused 5 doses out of 31 opportunities. -In February 2025, there was documentation Resident #21 refused 15 doses out of 28 opportunities. -In March 2025, there was documentation Resident #21 refused 5 doses out of 31 opportunities. -Resident #21 refused his aripiprazole on 3 consecutive days, 03/05/25, 03/06/25, and 03/07/25. -In April 2025, there was documentation Resident #21 refused 1 dose out of 22 opportunities from 04/01/25-04/22/25. Telephone interview with a pharmacist at the facility's contracted pharmacy on 04/28/25 at 2:45pm revealed:	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 273	Continued From page 118 -Aripiprazole was a medication that had to "build up" to reach a peak concentration. -If there were a break in administering the medication, it would not be effective. -Aripiprazole had to be administered continuously to be therapeutic. -If Resident #21 was refusing the medication too much to reach a therapeutic level, there would not be an improvement in his behaviors. -It would be safe to assume you would not see an improvement in Resident #21's behaviors based on the number of refusals. -Resident #21 would not be metabolizing the dose of aripiprazole administered before the next dose could be administered if he was refusing the medication. -Aripiprazole needed to be consistently administered for 4-6 weeks to be effective. Interview with a medication aide (MA) on 04/28/25 at 11:38am revealed: -Resident #21 told her he was not taking his aripiprazole. -Resident #21 told her she was trying to kill him when he refused to take the blue tablet. -Resident #21 would remove the aripiprazole, which was a blue tablet from his medication cup, and throw the tablet on the floor. -She knew Resident #21 needed to take the aripiprazole, so she began crushing the tablet and adding it to the resident's breakfast plate, and would make sure he ate the item she added the tablet to. -She thought it had been about one month since she started crushing Resident #21's aripiprazole. -She did not notify Resident #21's mental health provider (MHP), but she did tell the Special Care Unit Coordinator (SCC). Interview with the SCC on 04/25/25 at 10:49am	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 119 revealed: -The MA was supposed to let someone in management know if a resident refused a medication. -She was not aware Resident #21 had refused his aripiprazole. -If a medication was refused several days in a row, it could start losing it's effectiveness. -She did not see anything in telehealth notifying the primary care provider (PCP) about Resident #21's refusals. Interview with the Administrator on 04/29/25 at 4:53pm revealed: -She expected staff to let the PCP know the first day a resident refused medication. -If the PCP had been notified, the PCP would have given a solution. -She was concerned because missing medications could affect Resident #21's anxiety, agitation, and aggression from not being administered the medications as ordered. b. Review of Resident #21's electronic chart note dated 03/08/25 revealed: -He placed another resident in "headlock." -He refused to talk about the incident and stated, "Leave me alone." -He had several old scabs on top of his left hand, and blood was noted on the hand. -He refused for his hand to be looked at. Interview with the SCC on 04/28/25 at 3:51pm revealed: -On 03/08/25, Resident #21 put a [named] resident in a headlock. -She notified the facility's contracted PCP directly, but not the MHP about the incident on 03/08/25. -She had just started to work at the facility and was not aware of the facility's process at the time.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 273	Continued From page 120 Review of an incident and accident report dated 04/22/25 revealed: -Resident #21 had blood coming from his right forearm; the area was cleaned and bandaged. -The name of the facility's contracted PCP's office was notified. -Resident #21's family member was notified. Interview with Resident #21 on 04/23/25 at 8:28am revealed: -He and a [named] resident "got in a fight" last night, 04/22/25. -He did not remember why they were fighting. -He hit the [named] resident in the eye, "I knocked his eye out." Interview with the [named] resident on 04/23/25 at 8:37am revealed he had not fought with Resident #21. Review of an incident and accident report dated 04/28/25 at 3:14am revealed: -While doing rounds, the personal care aides (PCAs) heard yelling. -When they entered the room the yelling was coming from, and turned on the light, they saw Resident #21 standing over a [named] resident with a cane in his hand, and the [named] resident had blood gushing from his head. -Resident #21 was asked why he hit the [named] resident, and Resident #21 stated, he was trying to save his life. -Resident #21 also stated, "he told me to do it." Interview with the SCC on 04/28/25 at 3:51pm revealed: -The [named] resident who was injured by Resident #21 had returned from the emergency department (ED) and had 8 lacerations, with a	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 273	Continued From page 121	D 273		

total of 20 staples and a nasal bone fracture.
-The [named] resident had been moved out of Resident #21's room.
-Resident #21 had been sent to the ED by emergency medical services (EMS) to be evaluated, and when he returned, he would have 1:1 monitoring.

Telephone interview with a representative from the mental health crisis team on 04/29/25 at 11:01am revealed:
-He went to the facility on 04/28/25, to see what support he could provide with the situation involving Resident #21, since the EMS declined transport and the law enforcement did not get involved.
-Resident #21 agreed to be evaluated at the local hospital on 04/28/25.

Telephone interview with another representative with the mental health crisis team on 04/29/25 at 11:16am revealed that the only call they had received regarding Resident #21 was on 04/28/25.

Interview with a personal care aide (PCA) on 04/28/25 at 4:15pm revealed:
-She had seen Resident #21 throw a cup of water on another PCA.
-She did not recall the PCA's name, but the PCA no longer worked at the facility.
-She recalled Resident #21 getting into a fight with another resident because the resident was in his bed; she did not recall when this incident happened.
-She saw Resident #21 smack another resident because the resident ran over his foot with his wheelchair; she thought the MA completed an incident report.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 122 Interview with a MA on 04/24/25 at 3:40pm revealed: -She saw Resident #21 hit a [named] resident on the head with a brush "about 4 days ago." -She completed an incident report of her observation. Interview with the Administrator on 04/29/25 at 4:53pm revealed: -Staff should notify the provider about any incidents with the residents. -The provider was in the facility on Tuesdays and would sign the incident reports that were put in her folder. -All incident reports should always go in the provider's folder. -The providers could also be notified using the telehealth system (an electronic email system with the provider's office). Requests for additional incident reports for Resident #21 on 04/28/25 at 8:18am were not provided by the survey exit. _____ Telephone interview with Resident #21's court-appointed guardian on 04/28/25 at 2:54pm revealed: -She had not been notified Resident #21 had refused to take his aripiprazole. -Today, 04/28/25, was the first time she had been notified about any behaviors. -She was not notified of Resident #21 putting another resident in a headlock on 03/08/24. -If she had been notified, she would have asked if Resident #21's MHP had been notified for an assessment. -They had a crisis line available after hours to be notified and to obtain consent for treatment if necessary. -She expected the facility to notify her and the	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 123 MHP of any incidents involving Resident #21. Telephone interviews with Resident #21's MHP on 04/28/25 at 10:25am and 12:29pm revealed: -She knew Resident #21 was having behaviors, including hearing voices, when he first moved into the facility, and missed his Invega (used to treat schizophrenia) injection. -She changed the injection to Invega tablets, but because of the cost, it was not an option for Resident #21. -She then ordered aripiprazole 5mg for Resident #21. -No one had reported Resident #21 having behaviors since he was started on the aripiprazole. -Her initial plan was to increase Resident #21's aripiprazole 5mg if he had any behaviors, but since none had been reported, she had not increased the medication. -If she had known Resident #21 had been having behaviors, she would have increased the resident's medications. -If she had increased Resident #21's medications, he may or may not have had these behaviors, but medication would have been used to treat the behaviors. -She was not aware Resident #21 was not taking his aripiprazole as ordered. -If Resident #21 had missed doses, it could have contributed to his behavior. -Aripiprazole needed to be taken consistently for 3 weeks. -If Resident #21 was not taking the aripiprazole as ordered and was still having behaviors, then she would need to increase the medication. -If Resident #21 had not taken the aripiprazole for 3 consecutive weeks, she would not be able to determine the effectiveness of the medication. -She did not know Resident #21 had refused the	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 273	Continued From page 124	D 273		

medication, and she expected to be notified.

5. Review of Resident #4's FL-2 dated 01/28/25 revealed diagnoses included hypertension and dementia with behavioral disturbance.

a. Review of Resident #4's hospital discharge summary dated 04/11/25 revealed:
-Resident #4 was diagnosed with hematuria (blood in the urine).
-There was a note to follow up with a urologist, as soon as possible.
-The urologist's name, address, and telephone number were listed.

Interview with a medication aide (MA) on 04/24/25 at 8:12am revealed:
-The Special Care Unit Coordinator (SCC) was responsible for reviewing discharge papers and making follow-up appointments if needed.
-She knew Resident #4 had been to the hospital for blood in his urine.
-She did not know he was supposed to have a follow-up appointment with a urologist.

Telephone interview with Resident #4's family member on 04/29/25 at 4:16pm revealed:
-She did not know Resident #4 had been to the hospital for blood in his urine.
-She had never been contacted by the facility about anything related to Resident #4.
-If Resident #4 was supposed to have an appointment made, she expected the facility to coordinate.

Interview with the SCC on 04/24/25 at 2:27pm revealed:
-She knew Resident #4 had been to the hospital for blood on his penis.
-She let the facility's contracted primary care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 273	Continued From page 125	D 273		

provider (PCP) know Resident #4 had been sent out for an evaluation.
-The Administrator did not say anything about any new orders.
-Whoever received the discharge summary was responsible for making the follow-up appointments.

Interview with the Administrator on 04/29/25 at 4:53pm revealed:
-She thought the SCC had followed up on Resident #4's urology appointment.
-She was concerned that a follow-up appointment had not been made because Resident #4 could have something more serious going on.

Telephone interview with Resident #4's PCP on 04/25/25 at 9:53am revealed:
-The triage team had been notified Resident #4 had been sent to the emergency department (ED) and returned to the facility with a diagnosis of hematuria.
-She was not aware Resident #4 had not had a follow up appointment made with the urologist.
-Resident #4 would need further evaluation to determine the cause of the hematuria.
-Resident #4 could have a bladder mass or other issue that she would not know how to treat until evaluated.

Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable.

b. Review of Resident #4's PCP after-visit summary dated 01/28/25 revealed:
-Resident #4 was noted to have acute weakness.
-Resident #4 had fallen, though it was unclear how recent the falls were.
-Given the resident's age and comorbidities, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 273	Continued From page 126	D 273		

weakness could be due to multiple factors.
-Physical therapy (PT) and occupational therapy (OT) were ordered to evaluate and treat Resident #4 to assist in reduction of falls, injury, mobility, and strength.
-It was in her judgment that Resident #4 could demonstrate improved function as a result of PT/OT and would be able to maintain mobility and quality of life.
-The after-visit summary was electronically signed by the PCP.

Telephone interview with a representative from the local health department's home health agency on 04/24/25 at 12:33pm revealed:
-Their agency provided home health services at the facility.
-She did not see a referral for Resident #4 for any home health services, including PT/OT.
-She looked back from January 2025 until current and did not see a referral for PT/OT for Resident #4.

Interview with a MA on 04/24/25 at 8:12am revealed:
-Resident #4 had not received any PT/OT that she was aware of.
-He had not had any falls.

Interview with the SCC on 04/24/25 at 2:27pm revealed:
-She did not know anything about Resident #4 receiving PT/OT.
-She did not start working at the facility until March 2025.
-She had not observed Resident #4 having any problems with ambulation.

Telephone interview with Resident #4's PCP on 04/25/25 at 9:53am revealed:

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D 273	Continued From page 127 -The order for PT/OT was from a previous provider to restore function and gait stability. -There was no documentation the office had been notified that PT/OT had not been provided. -She was concerned that without PT/OT the reasons the order was initially initiated, would not be resolved. Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable. 6. Review of Resident #1's FL-2 dated 12/21/24 revealed: -Diagnoses included dementia, schizoaffective disorder, hypertension, and a history of cerebrovascular disease (CVA). -There was an order for Aripiprazole (an antipsychotic medication used to treat the symptoms of schizophrenia) 10mg at bedtime. Review of an incident report dated 03/23/25 at 1:00pm revealed: -Resident #1 was fighting with another resident because the resident was in her chair. -Resident #1 scratched a second resident's arm during the altercation. -Even after asking Resident #1 to stop, she continued to fight the first resident over the chair. -Resident #1 went to her room and slammed her door. Interview with a personal care aide (PCA) on 04/28/25 at 4:15pm revealed she had seen Resident #1 tell another resident to get out of her seat, but otherwise Resident #1 seemed "really sweet." Interview with a medication aide (MA) on 04/24/25 at 8:12am revealed:	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 128 -She completed the incident report for Resident #1 fighting on 03/23/25. -Resident #1 hit another resident. -When they were redirecting Resident #1, she was "cussing" everybody out. -Resident #1 did not have any as-needed (PRN) medications for agitation. -She gave the incident report to the special care unit coordinator (SCC) or slid under her door if she was not in the facility. Telephone interview with Resident #1's mental health provider (MHP) on 04/25/25 at 4:50pm revealed: -She was not aware that Resident #1 had reported behaviors of fighting with other residents. -She thought Resident #1 had been stable, and she was going to possibly reduce her medications for behaviors. -She expected to be notified of behaviors so she would know how to manage her medications. Interview with the Administrator on 04/29/25 at 4:53pm revealed: -Staff should notify the provider about any incidents with the residents. -The provider was in the facility on Tuesdays and would sign the incident reports that were put in her folder. -All incident reports should always go in the provider's folder. -The providers could also be notified using the telehealth system (an electronic email system with the provider's office). Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 273	Continued From page 129 7. Review of Resident #3's current FL-2 dated 07/22/24 revealed diagnoses included hypertension, chronic kidney disease, congestive heart failure, diabetes mellitus type 2, bilateral leg edema, schizophrenia, and kidney failure. Review of Resident #3's Primary Care Provider's (PCP) visit note summary dated 03/18/25 revealed: -Resident #3's reported worsening dyspnea. -Resident #3 had a 60% reduction in ambulation. Review of Resident #3's PCP visit note summary dated 04/15/25 revealed: -He had physical impairment, deconditioning, and difficulty walking. -Physical Therapy (PT) would be ordered for poor activity tolerance, poor balance, and the need of additional ambulatory support. Review of Resident #3's signed PCP order dated 04/15/25 revealed there was an order for PT for evaluation and treatment, strengthening, energy conservation, and balance coordination. Interview with Resident #3 on 04/29/25 at 9:20am revealed: -He would sit on his rollator when he got tired and short of breath when walking to the dining room and medication cart. -He was not receiving PT at this time; he had no problem with PT coming to walk with him. Telephone interview with a representative from the facility's contracted Home Health Agency (HH) on 04/25/25 at 2:45pm revealed: -The HH agency had not receive a referral for PT dated 04/15/25 for Resident #3. -The referrals were faxed to the HH agency by a	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 273	Continued From page 130	D 273		

representative from the facility.
-Resident #3 had never been seen by the HH agency.

Telephone interview with Resident #3's Primary Care Provider (PCP) on 04/25/25 at 4:10pm revealed:
-She ordered a PT referral on 04/15/25 for Resident #3 because he was short of breath and deconditioned.
-The facility staff reported he was having increased shortness of breath when he was up and about.
-When she spoke with Resident #3 he verbalized he had shortness of breath with ambulation.
-She expected the PT referral to be forwarded to an agency within 3 to 5 days to initiate PT.

Interview with the Resident Care Coordination (RCC) on 04/28/25 at 2:46pm revealed:
-She would print the PCPs order for the referral and fax it to the appropriate place for residents in the AL.
-She did not recall Resident #3 having an order for a PT referral.
-The PT referral should have been faxed to the facility's contracted HH Agency.

Interview with the RCC on 04/29/25 at 9:10am revealed she had spoken with Resident #3 yesterday afternoon, 04/28/25, and he did not want PT.

Interview with the Administrator on 04/29/25 at 3:02pm revealed:
-Referrals were handled by the RCC.
-The RCC would fax referrals to the appropriate agency and follow up with the agency the next day to ensure the agency received the referral.
-She expected the referrals to be faxed the day

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D 273	Continued From page 131 they were received. -She did not know why the PT referral was not sent to the HHA agency. -The PT referral should have been faxed the day it was received and followed up the next day. _____ The facility failed to ensure referral and follow up for 7 sampled residents including a resident, who was diagnosed with stage three lymphoma and missed scheduled appointments for lab work and consultations needed prior to beginning cancer treatments causing treatments to be delayed (#2). Another resident (#14), who had a diagnosis of rectal cancer missed multiple MRIs, PET scans and oncology appointments delaying the staging of her cancer and treatments.Resident #15 who was choking and vomiting while eating and drinking at meals had a referral for an evaluation for a swallowing evaluation with a speech therapist that was not scheduled. A fourth resident (#21), who refused to take multiple doses of a medication used to treat behaviors and had multiple incidents involving other residents, resulting in a resident being severely injured; the provider was not made aware and had the provider been notified of the behaviors, she would have made medication adjustments. This failure resulted in serious physical harm and neglect which constitutes an A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/29/25. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MAY 29, 2025.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 276	Continued From page 132 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure documentation of orders for 1 of 1 sampled residents (#2) related to checks for finger stick blood sugar (FSBS). The findings are: Review of the facility's undated FSBS monitoring policy revealed: -The purpose was to ensure safe and accurate monitoring of residents' blood glucose levels using FSBS testing. -To be in compliance with physicians' orders, and resident care plans. -To record FSBS readings in the resident's electronic medication administration record (eMAR) immediately after testing. -The documentation of any interventions taken due to abnormal readings and to notify the physician of critical values as outlined in the physicians' orders. -The failure of staff to adhere to FSBS monitoring policies could result in disciplinary actions and would be addressed by the Administrator and Resident Care Coordinator (RCC). Review of Resident #2's current FL-2 dated 01/28/25 revealed diagnoses included dysphagia, chronic pain, hyperlipidemia, anxiety, muscle	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 276	Continued From page 133 weakness, edema, and chronic obstructive pulmonary disease (COPD). Review of Resident #2's personal care aide (PCP) after visit notes dated 02/11/25 revealed Resident #2 had an order for FSBS check and document results three times daily before meals. Review of Resident #2's signed physician's orders dated 04/01/25 revealed an order for FSBS checks three times daily before meals. Review of Resident #2's electronic medication administration record (eMAR) for February 2025 revealed: -There was an entry for FSBS check three times daily scheduled at 7:00am, 11:00am and 5:00pm. -Resident #2 was in the hospital from 02/18/25 to 02/28/25. -Resident #2's FSBS checks were not obtained for 8 of 51 opportunities from 02/01/25 to 02/17/25. Review of Resident #2's eMAR for March 2025 revealed: -There was an entry for FSBS check three times daily scheduled at 7:00am, 11:00am and 5:00pm. -Resident #2 was in the hospital from 03/01/25 to 03/03/25. -Resident #2's FSBS checks were not obtained for 5 of 84 opportunities from 03/03/25 to 03/31/25. Review of Resident #2's eMAR for April 2025 from 04/01/25 to 04/22/25 revealed: -There was an entry for FSBS check three times daily scheduled at 7:00am, 11:00am and 5:00pm. -Resident #2's FSBS checks were not obtained for 2 of 60 opportunities from 04/01/25 to 04/22/25.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 276	Continued From page 134 Interview with Resident #2's PCP on 04/29/25 at 12:00pm revealed: -Resident #2 had an order for FSBS checks done three times a day before meals because Resident #2 was administered insulin (used to regulate glucose levels in the blood) three times a day. -Resident #2 did not have parameters with her FSBS results. -Resident #2's FSBS results were within her normal range but she wanted the staff to see the FSBS results so they would know whether to give her an injection of insulin or not. -The staff had reached out to her when Resident #2's FSBS results were low, and she had given them a verbal instruction to hold her insulin. -If staff were not doing the FSBS checks then, how would they know what Resident #2's blood sugar levels were. -It was a tool for the staff and a way for her to track the resident's FSBS results. -She expected her orders to be followed. Interview with Resident #2 on 04/25/25 at 10:30am revealed: -She had FSBS checks done three times a day. -The a medication aide (MA) did them before they gave her an insulin injection. -There were times when the MA forgot to check her FSBS. -Different MAs did them and different MAs did not. Interview with a MA on 04/23/25 at 2:55pm revealed: -Resident #2 had FSBS checks three times a day. -She obtained them before she gave her an insulin injection. -Resident #2 refused them sometimes or wanted	D 276		

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D 276	Continued From page 135	D 276		

to sleep instead of having her FSBS checked.
-She documented on the eMAR when Resident #2 was at the hospital, asleep or refused to let her do a FSBS check.
-She did not know why there were blanks in the eMAR.
-She always obtained Resident #2's FSBS checks and documented them.

Interview with the RCC on 04/29/25 at 11:30am revealed:
-The MAs should have documented FSBS results on the eMAR each time they did a FSBS check.
-If there was a reason like a refusal or the resident was doing something at the time then they should try a second time to do the FSBS check.
-If there was a reason they did not or could not obtain a FSBS check then they should always document the reason.
-If there were holes or blanks on the eMAR the only reason was the MA never "clicked" off the FSBS on the eMAR.
-There should never be blanks on the eMAR.
-If there was no documentation, it was not done.
-The FSBS checks were ordered by the PCP to monitor Resident #2's blood sugars and for a way for the MAs to see what her levels were.

Interview with the Administrator on 04/29/25 at 4:45pm revealed:
-She expected the MAs to do Resident #2's FSBS checks as ordered.
-There should never be blanks on the eMAR.
-The MAs should always document a reason why a FSBS was not done.
-Resident #2 did not always want to have her FSBS checked, and the MAs should have documented the refusal.
-The MAs got in a hurry and would forget to

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D 276	Continued From page 136 document on the eMAR after they did the FSBS check. -If it was not documented, it did not get done.	D 276		
D 277	10A NCAC 13F .0902 (d) Health Care 10A NCAC 13F .0902 Health Care (d) The following shall apply to the resident's physician or physician service: (1) The resident or the resident's responsible person shall be allowed to choose a physician or physician service to attend the resident. (2) When the resident cannot remain under the care of the chosen physician or physician service, the facility shall assure that arrangements are made with the resident or responsible person for choosing and securing another physician or physician service within 45 days or prior to the signing of the care plan as required in Rule .0802 of this Subchapter. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 1 of 1 sampled residents (#2) was allowed to choose a physician (#2) and did not secure a physician for 1 of 1 sampled residents (#20) within 45 days when the resident could not remain under the care of the chosen physician (#20). The findings are: 1. Review of Resident #2's current FL-2 dated 01/28/25 revealed diagnoses included dysphagia, chronic pain, hyperlipidemia, anxiety, muscle weakness, edema, and chronic obstructive	D 277		

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D 277	Continued From page 137 pulmonary disease (COPD). Interview with Resident #2 on 04/23/25 at 10:50am revealed: -She was going to the Veterans Administration (VA) for her appointments before she was admitted to the facility in January 2025. -She was diagnosed with lymphoma in March of 2025 and wanted to have her treatments and hematologist appointments at the VA. -Her primary care provider (PCP) was at the VA and she wanted to continue with the same PCP. -She wanted her medications and lab work done at the VA. -After she was diagnosed with lymphoma the Administrator and the Resident Care Coordinator (RCC) wanted her to go have procedures done at the local hospital and not the VA. -The Administrator wanted her to see the facility's PCP and to get her medications from the facility's contracted pharmacy so it would be less chaotic and confusing. Telephone interview with a Registered Nurse from the PCP's office at the VA on 04/25/25 at 2:35pm revealed: -Resident #2 had been coming to the VA for her appointments, treatments, labs and medication. -The VA would not pay for her to use outside pharmacies or go outside of the VA for appointments and PCP's visits unless she got community referrals for them. -Community referrals were only given by the VA when they could not schedule an appointment because they were behind or did not have open appointments and the resident needed to be seen quicker. Interview with the RCC on 04/24/25 at 3:50pm revealed:	D 277		

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D 277	Continued From page 138 -It was difficult to get Resident #2 to her appointments at the VA because it was an hour away. -The VA scheduled appointments with Resident #2 and sent her reminders; they did not get to appointment reminders until after the appointment date. -It was difficult to get documents and after visit reports from the VA. -Resident #2's medications had come from the VA without an order, and they could not administer them to the resident without an order. -The hematologist at the VA told Resident #2 she could have a community referral for a consultation at the local cancer center, but the resident wanted to go to the VA. -She wanted to be seen by the PCP at the VA. Interview with the Administrator on 04/28/25 at 4:35pm revealed she wanted everyone to be seen by the facility's physician so she did not have to worry about transportation or documentation; it would prevent confusion. Interview with the Administrator on 04/29/25 at 10:25am revealed: -Resident #2 had always been seen by the facility's contracted PCP. -Resident #2 told her in March 2025 she wanted to move closer to the VA so she could go to the VA for her cancer treatments. -She thought the physicians from the VA were trying to get Resident #2's appointments scheduled closer to the facility. -She thought Resident #2 wanted to use the facility's pharmacy and not the pharmacy at the VA; it was easier to use the facility's pharmacy. -She had not asked Resident #2 where she wanted to go for her physician appointments, lab work, treatments or procedures.	D 277		

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D 277	Continued From page 139 -Resident #2 had not expressed wanting to change from the facility's pharmacy and PCP to the PCP and pharmacy at the VA and no one had reported it to her. -It was the facility's responsibility to get Resident #2 to the VA if that was where she wanted to go. -Resident #2 had the right to go to the PCP of her choice. 2.Review of Resident #20's current FL-2 dated 05/24/24 revealed diagnoses included dementia. Review of Resident #20's physician's after visit report dated 06/17/24 revealed: -Resident #20 had cognitive and communication limitations which made it difficult to obtain medical status. -Resident #20's diagnoses included schizophrenia, anxiety, depression, dementia, vitamin D deficiency and constipation. -After repeated visits the physician was unable to engage with Resident #20. -She appeared medically stable but had not been taking any of her medications for two months. -She would not allow a physical exam. -She continued to eat, drink and use the toilet independently. -The physician recommend the resident be discharged from the physician's care all together. -The physician instructed the facility staff to call the physician's office to reestablish service if or when she showed signs of deterioration or change. Review of Resident #20's electronic medication administration record (eMAR) for February 2025 and March 2025 revealed: -There were entries for three medications each scheduled once daily. -In February 2025, she refused the medications	D 277		

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D 277	Continued From page 140 25 of 28 opportunities. -In March 2025 she refused her three medications 29 of 31 opportunities. Review of Resident #20's eMAR for April 2025 from 04/01/25 to 04/29/25 revealed: -There were entries for two medications each scheduled once daily. -Resident #20's medication was not documented as administered from 04/27/25 to 04/29/25; the eMAR was blank. -She refused one of her medications 20 of 26 opportunities and she refused the second medication 23 of 26 opportunities. Review of Resident #20's progress notes dated from 03/03/25 to 04/27/25 revealed: -On 03/03/25, 03/18/25, 04/09/25, and 04/27/25, the Administrator attempted to contact Resident #20's guardian to discuss the resident's refusal of care and activities of daily living (ADLs); the Administrator left a message at the number provided. -On 03/05/25, Resident #20 was agitated and aggressive. -On 04/21/25, Resident #20 was extremely combative and argumentative with staff; it took 4 to 5 staff to assist her out of her bed and ambulate to the shower room because she attempted to hit and bite at the staff. Observations of Resident #20 on 04/22/25 at various times between 8:00am to 5:00pm revealed: -She was in her bed with a winter coat on for much of the day. -She did not speak English. -She did not interact with other residents or staff. -She did not participate in meals, snacks or activities.	D 277		

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D 277	Continued From page 141 Interview with the facility's primary care provider (PCP) on 04/29/25 at 12:00pm revealed: -The facility staff had reached out to her about Resident #20 today, 04/29/25, because they realized the resident did not have a PCP. -She had not interacted with Resident #20 before. -She had not seen Resident #20 yet but was going to attempt to assess her today. -She felt Resident #20 should have been seen at least once a year. Interview with Resident #20's guardian on 04/28/25 at 10:45am revealed: -He had only been Resident #20's guardian for about three months. -He was contacted by the facility today for consent for a new PCP for Resident #20. -The facility staff told him she refused medications, and she needed to have a PCP. -He visited Resident #20 at the facility on 04/23/25. -He spoke to staff, and they did not tell him that she did not have a PCP. -He was not aware Resident #20 did not have a PCP until the facility called him today, 04/28/25. -Resident #20 had a language barrier that made it difficult to provide care for her. -Resident #20 could speak English in a few short sentences. -He would like the facility to provide him with more information about her care, refusals and physicians visits. Interview with the Resident Care Coordinator (RCC) on 04/28/25 at 9:00am revealed: -Resident #20 did not speak much English and did not respond to translation through a telephone application. -Resident #20 did not want the staff near her; she	D 277		

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D 277	Continued From page 142 became agitated and combative. -She and the Administrator found out over the weekend that Resident #20 had been discharged from the physician's care. -One of the medication aides (MAs) went to contact the PCP about the resident's medication refusals and was told Resident #20 had been discharged from their office. -They had no reasons to reach out to the PCP before this weekend. Interview with the Administrator on 04/28/25 at 4:35pm revealed: -She discovered Resident #20 did not have a physician yesterday, 04/27/25. -When the facility's staff contacted the PCP's office on 04/27/25 to let them know Resident #20 was refusing medication, they told the MA Resident #20 was discharged from their care in July 2024. -She would have never let Resident #20 go without a physician for that long if she had known. -It would have been caught sooner if staff had been filing and doing audits. -She had attempted to reach Resident #20's guardian yesterday; she left a message and was going to continue to call until she reached someone. -She was not sure how this had affected Resident #20 to not have a PCP.	D 277		
D 285	10A NCAC 13F .0904(a)(4) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (a) Food Procurement and Safety in Adult Care Homes: (4) There shall be a three-day supply of perishable food and a five-day supply of	D 285		

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D 285	Continued From page 143 non-perishable food in the facility based on the menus established in Paragraph (c) of this Rule for both regular and therapeutic diets. For the purpose of this Rule "perishable food" is food that is likely to spoil or decay if not kept refrigerated at 40 degrees Fahrenheit or below, or frozen at zero degrees Fahrenheit or below and "non-perishable food" is food that can be stored at room temperature and is not likely to spoil or decay within seven days. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure a 3-day supply of perishable food and a 5-day supply of nonperishable food was always available. The findings are: Review of the facility's current census on 04/22/25 was 55 residents. Observation of the food supply in the kitchen on 04/22/25 at 11:05am revealed: -There were two 5-pound (lb.) tubs of frozen chili with a total of fifty 3 ounces (oz) servings. -There were two 10lb bags of frozen fish with 80 servings. -There was a 5lb bag of frozen pork chops with twenty-five 4oz servings. -There was a 10lb bag of frozen chicken with fifty 3oz servings. -There were 3 pans of frozen lasagna; each pan had 12 servings for a total of 36 servings. -There was a 2lb bag of frozen okra with a 10	D 285		

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D 285	Continued From page 144 servings. -There were various bags of frozen rolls, and frozen hash browns. -There were twelve 1lb packages of bologna with 36 servings in a cooler. -There were two bags of hotdog buns, four loaves of sandwich bread, and a bag of dinner rolls. -There was one #10 can (a large can with 21 half cup servings per can) of pineapple tidbits, five #10 cans of sweet potatoes, six #10 cans of spinach and four #10 cans of collard greens. -There was one 48oz bottle of apple juice and one 48oz bottle of grape juice with eight 8oz servings in each bottle. -There was one 10lb bag of dried noodles with fifty 3oz prepared servings. -There were two bags of brownie mix. -There was an opened two-pound box of rice. -There was a 52oz bottle of orange juice with five 8oz servings. Observation of the kitchen on 04/22/25 at 11:30am revealed a food truck was delivering the weekly food order. Observation of the lunch meal on 04/22/25 at 12:00pm revealed: -Spaghetti with tomato sauce, ground beef, cut up hot dogs, peas and carrots was served. -Some residents were moving the peas and carrots from the sauce to the side of their plates. Observation of the lunch meal on 04/23/25 at 12:15pm revealed: -A resident was served a turkey and cheese sandwich as her entrée. -She asked the personal care aide (PCA) for some mustard or mayonnaise for her sandwich. -The PCA went to the kitchen and returned with two packets of ketchup.	D 285		

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D 285	Continued From page 145 -The PCA told the resident the kitchen did not have any mayonnaise or mustard. -The resident asked the PCA if she could take the sandwich to the kitchen and ask them to spread some mayonnaise or mustard on her because she just needed something on her sandwich. -The PCA told the resident there was no mayonnaise or mustard in the kitchen. Review of the food delivery invoices for April 2025 revealed: -The food was delivered every Tuesday. -The invoices averaged $2,400.00 each delivery. Interview with a cook on 04/22/25 at 12:35pm revealed: -She came to work at 8:00am today, 04/22/25, so she did not cook breakfast. -The Administrator cooked breakfast. -She prepared spaghetti for lunch today. -She did not use a recipe and she substituted the meal that was on the menu because the fish was not thawed. -She made spaghetti with 10 pounds dry pasta, two large cans of tomato sauce and added one pound of ground beef, 36 to 48 cut up hot dogs, one large can of mixed vegetables. -She added the vegetables to the spaghetti to change "things up" because they were on the menu anyway. -She served broccoli with cheese sauce; she used 7 to 8 heads of fresh broccoli. -She used the cut up hot dogs because she usually used sausage and there was not any. -There was always food in the kitchen; she would make do with what was there if there was something she did not have. Review of the Food and Drug Administration recommended serving size and package yield	D 285		

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ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 285	Continued From page 146 information: -One #10 can of food served 21 half cup servings of vegetables or fruit. -One pound of cooked ground beef yielded 4 three-ounce servings. -One hot dog was one serving. -One head of fresh broccoli served 6 one cup servings; there were 48 one cup servings from 8 heads of broccoli. Interview with a cook on 04/28/25 at 5:35pm revealed: -Sometimes on the weekends she did not have everything she needed to make the meals on the menu so she changed ingredients around. -She ran out of fruit on the weekends. Interview with two residents on 04/22/25 at 12:35pm revealed: -The kitchen did not run out of food that they knew of. -They were usually served very small portions. -They never knew what was on the menu for the week. -They did not always have milk, bananas or orange juice. -They ate a lot of fish and deli meat. Interview with a third and a fourth resident on 04/22/25 at 2:20pm revealed: -They did not like the spaghetti with the hot dogs and mixed vegetables. -They did not know why there were vegetables and hot dogs in the spaghetti. -They had never had spaghetti served to them that way before. Interviews with the Dietary Manager (DM) on 04/23/25 at 7:30am and 1:14pm revealed: -She did not do the food orders.	D 285		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 285	Continued From page 147 -A medication aide (MA) did the food orders for the kitchen. -She told the MA what she needed based on the menu. -Food was delivered once a week on Tuesdays. -Sometimes the Administrator would go to the grocery store to pick up small items. -She would tell the Administrator she needed something, and the Administrator would get it. -On 04/22/25, the Administrator had to go buy sausage for breakfast. -She did not know when items were not ordered or not delivered on the food truck. -Most of the time there was enough food to last from one delivery to the other. -The kitchen staff used everything they could between deliveries. -Sometimes there would be 2 to 3 pork chops or hamburgers left in a case they did not cook. -Sometimes they would run out of a main ingredient and substitute it with something else. -Tonight, 04/23/25, she did not have hard boiled eggs or prepared egg salad so she prepared fish. -For the lunch meal today, she had to prepare lasagna because she did not have the ingredients to make the Italian seafood dish. -She had to substitute items on the menu 2 to 3 times a week because she did not have the ingredients. Interview with a MA on 04/24/25 at 12:45pm revealed: -She ordered the food for the kitchen staff. -She used the menu to order her food. -She ordered what was needed from Tuesday to Tuesday; the food delivery came in on Tuesdays. -She called the DM while she was working on the order and asked her what she needed. -She entered the order into the computer and the Owner of the facility looked at it and approved it	D 285		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 285	Continued From page 148 on Monday. -The Owner told her to keep the food order at $2,500.00 each week. -The Owner would tell her not to order something and to remove it if the order was too high. -The Owner would remove seasonings or ice cream. -She did not remove food needed for main menu items. -It had been months since the kitchen ran out of anything. -She ordered about 20 pounds of ground beef a week. -The cook used about 15 pounds of ground beef when she made spaghetti; it took the whole 15 pounds to feed the whole building. -When sloppy Joes and spaghetti were on the menu the same week she ordered two cases of ground beef. -She ordered two cases of eggs a week; the cooks used five cartons every time they prepared eggs for breakfast. -She tried to follow the weekly menu as close as possible. -Sometimes the food vender would be out of an item, and she would have to replace it on the order or sometimes an item would not be on the delivery. -The Administrator would go to the grocery store for items she could not get or if something ran out, but that was not often. -The Administrator had to buy eggs on 04/22/25, because the vendor was out of eggs. -She did not know how much food was kept on hand in the kitchen; it could not be much because there were no extras of any food ordered due to the budget. -She had never been told there needed to be a certain amount of food to be kept available. -The kitchen always had bread, peanut butter,	D 285		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 285	Continued From page 149 and jelly. Interview with the Administrator on 04/28/25 at 5:00pm revealed: -She purchased items for the residents' snacks at the grocery store. -The DM and a MA did the food orders for the kitchen. -If she or the DM felt like they were going to run out of a food item then she will go to the grocery store to purchase it. -The food delivery was normally substantial. -She had to purchase food items in the past like fresh cabbage, or fresh potatoes because they did not come in with the delivery and the items were needed for the menu. -She did not have to make routine purchases of random food because the kitchen ran out of something. -She expected the DM to follow the menu as closely as possible. -The residents did not go without a menu item; food items were always substituted. -She knew there was supposed to be a three-day supply of perishable food and a five-day supply of nonperishable food on hand. -She did not look at the kitchen to see if there was a three-day supply and a five-day supply. Telephone interview with the Owner on 04/29/25 at 2:54pm revealed: -The food delivery came every Tuesday. -One of the MAs did the weekly food order for the facility. -The MA ordered food based on the week-at-a-glance menu. -The food vender would deliver extra items during the week if there was an item that was needed, or she could go to the grocery store. -The facility staff only went to grocery store for	D 285		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 285	Continued From page 150 items that the food vender did not deliver on the weekly food delivery. -She reviewed the order before the MA placed the order to be sure it was done according to the menus. -She did not alter the order once the MA completed it; she did not want to throw a menu off. -The kitchen staff were supposed to follow the menus as closely as they could, including the portions sizes and recipes. -Anything needed for breakfast and lunch on Tuesdays should already be in the facility; they should not be waiting on a food delivery for menu items for those meals. -She was not aware of the kitchen staff running out of food or serving smaller portions to residents. -There should have been plenty of perishable and nonperishable food on hand in the kitchen. -The Administrator was new but one of her responsibilities would be to do an inventory in the kitchen to make sure there were 3-days of perishable and 5-days of nonperishable food.	D 285		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff.	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 296	Continued From page 151 This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure a therapeutic diet menu was available for staff guidance when preparing meals for 1 of 1 sampled residents (#2) who was ordered a low concentrated sweets (LCS) diet. The findings are: Review of Resident #2's current FL-2 dated 01/28/25 revealed diagnoses included dysphagia, chronic pain, hyperlipidemia, anxiety, muscle weakness, edema, and chronic obstructive pulmonary disease (COPD). Review of Resident #2's physician's signed diet order dated 03/25/25 revealed: -She had an order for a LCS diet. -The diet allowed half portions of regular desserts and possibly smaller amounts of starch food depending on the rest of the meal. Observation of Resident #2 on 04/23/25 at 12:15pm revealed: -Resident #2 was served a turkey and cheese sandwich, cooked squash, a slice of coconut pie, pink lemonade, and water. -She requested a second piece of pie. -She told the personal care aide (PCA) she wanted a second piece because she did not eat much for lunch. -She ate 100% of the two slices of pie, and she ate none of her turkey sandwich and her squash. Interview with Resident #2 on 04/23/25 at 11:30am revealed: -She was on a "diabetic diet". -Sometimes she ate fruit instead of the desserts	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 296	Continued From page 152	D 296		

that were served to the other residents.
-She tried to watch what she ate in the dining room because she did not want her [blood] sugar to go too high.
-She did not know if she got sugar free items.

Interview with Resident #2's primary care provider (PCP) on 04/29/25 at 12:30pm revealed:
-Resident #2 was ordered a LCS diet because she was diagnosed with diabetes and on medication.
-The LCS diet was lower in sugars and carbohydrates in an attempt to help control spikes in her glucose in her blood.
-She expected the facility staff to follow her orders for the LCS diet.

Interview with the cook on 04/22/25 at 9:15am revealed:
-She served residents on a LCS diet the same menu as the other residents.
-She used the week at-a-glance menu and did not use recipes when she cooked; she knew how to cook so she did what she knew.
-When she cooked foods for the menu, she did not use sugar.
-They also gave sugar free items like unsweetened apple sauce and sugar substitutes for the residents' tea and coffee.
-The coconut pie was not sugar free.

Interviews with the Dietary Manager (DM) on 04/23/25 at 7:30am and 9:30am revealed:
-The kitchen staff had therapeutic menus they followed when they prepared meals.
-She had a new menu and was on cycle one week three of the menu, but she had not been given the corresponding therapeutic diet menu for the new menu she was using.
-She thought the therapeutic diet menu included

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 296	Continued From page 153 the LCS diet. Interview with a PCA on 04/24/25 at 9:35am revealed there were no residents on a LCS diet. Interview with the Resident Care Coordinator (RCC) on 04/28/25 at 9:10am revealed: -She went into the dining room and observed meals three times a week. -All residents who were diabetic were ordered a LCS diet. -All the residents who were ordered a LCS diet were served the same trays as the residents who were on regular diets. -The kitchen staff was not following the therapeutic diet menu; they needed to find the therapeutic diet menu for a LCS diet and follow it. Interview with the Administrator on 04/28/25 at 4:00pm revealed: -She knew some of the residents who were diabetic were ordered a LCS diet. -The PCP signed a diet order form that included the LCS diet; so there should have been a therapeutic diet menu for the diet. -If there was a resident on a LCS diet, the kitchen staff needed to have a therapeutic diet menu for the diet. -She printed the therapeutic diet menus for the kitchen on 04/22/25; there should have been a LCS diet on the menu. -She did not check the therapeutic diet menu she printed for the DM on 04/22/25 for a LCS diet. -The DM should be ensuring the cooks were using the therapeutic diet menu to prepare and serve meals to the residents who were ordered a LCS diet. -The DM should have let her know there was not a LCS therapeutic menu.	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 310	Continued From page 154	D 310		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure therapeutic diets were served as ordered for 2 of 4 sampled residents (#3 and #15), including a resident who was ordered a liberal renal diet (#3) and a resident who was ordered a pureed diet with honey thickened liquids; and nutritional supplements for 7 of 7 sampled residents (#3, #4, #7, #8, #9, #14, and #19). The findings are: 1. Review of Resident #3's current FL-2 dated 07/22/24 revealed diagnoses included chronic kidney disease, hypertension, acute congestive heart failure, and anemia. Review of Resident #3's signed physician's orders dated 04/01/25 revealed: -Thre was an order for a liberal renal diet. -The diet order identified a liberal renal diet as a diet for residents with acute, chronic or end stage renal disease and was appropriate for both pre-dialysis and hemodialysis. Review of the recommendations from The	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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) COMPLETE DATE
D 310	Continued From page 155 Academy of Nutrition and Dietetics revealed: -A liberal renal diet was recommended for people with kidney disease. -A liberal renal diet was important because it helped to control the intake of phosphorus, potassium and sodium. -Foods to avoid or eat in moderation while on a liberal renal diet included chocolate and milk because they contain higher amounts of phosphorus; potatoes, milk, lemonade, pineapples and orange juice because they contain higher levels of potassium; prepared foods including canned tomato products, sausage, hot dogs and deli meats because they contain high levels of sodium. Observation of the breakfast meal on 04/22/25 at 8:15am revealed: -Resident #3 was served eggs, sausage patties, a waffle with syrup, milk, water and orange juice. -Resident #3 ate 100 percent of his egg, waffle, milk and orange juice and none of his sausage patty. Observation of the lunch meal on 04/22/25 at 12:00pm revealed: -Resident #3 was served a grilled ham and cheese sandwich, a large brownie with chocolate frosting, milk, water and a grape flavored beverage made from a drink mix. -Resident #3 ate 100 % of his grilled ham and cheese sandwich, chocolate brownie with frosting, milk and grape flavored beverage. Observation of the dinner meal on 04/23/25 at 5:00pm revealed: -Resident #3 was served a sloppy Joe on a bun, French fries, green peas, pineapple tidbits, milk, lemonade, and water. -He ate 100 percent of the sloppy Joe and French	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 310	Continued From page 156	D 310		

fries, 25 percent of the pineapple tidbits, and he drank 100 percent of his milk, 50 percent of his lemonade, and 75 percent of his water.

Interview with the cook on 04/22/25 at 9:15am revealed:
-She did not follow the therapeutic diet menu for liberal renal diet.
-None of the residents had an order for a liberal renal diet.
-She used the week-at-a-glance menu and did not use recipes when she cooked; she knew how to cook so she cooked what she knew.
-The breakfast meal on 04/22/25 included eggs, waffles, sausage, milk and orange juice.
-For lunch she prepared spaghetti with canned tomato sauce, ground beef and cut up hot dogs.
-She made and served a chocolate brownie with frosting.

Interview with the Dietary Manager (DM) on 04/23/25 at 7:30am revealed:
-The kitchen staff had therapeutic menus they followed when they prepared meals.
-They had a therapeutic diet menu for a liberal renal diet but there were no residents who were ordered that diet, so they did not need to follow it.
-She had a new menu and was using cycle one, week three of the new menu.
-She had not been given a corresponding therapeutic diet menu for the new menu cycle and week she was using.

Interview with Resident #3 on 04/29/25 at 2:45pm revealed:
-He was not on a liberal renal diet.
-The staff at the dialysis clinic wanted him to eat more proteins.
-The dialysis clinic did not want him to eat things like ham, cheese, potato chips or sausage.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 310	Continued From page 157 -He ate potato chips last night, 04/28/25, at dinner. -He ate things like sloppy Joes, orange juice, grilled ham and cheese sandwiches, and French fries. -He did not like bananas or breakfast sausage. Interview with Resident #3's primary care provider (PCP) on 04/29/25 at 12:50pm revealed: -Resident #3 was ordered a liberal renal diet because he was on dialysis for kidney disease. -His diet should include low sodium and avoiding potassium. -Foods like tomatoes, potatoes, citrus, and processed foods should be avoided. -If Resident #3's potassium became too high it might not be filtered out during dialysis, and he could have cardiac arrhythmia. -She expected the facility to follow her orders. Telephone interview with the Registered Dietitian (RD) from the dialysis clinic on 04/29/25 at 1:20pm revealed: -She had spoken to the Resident Care Coordinator (RCC) at the facility but thought the RCC had changed since she spoke to her. -She wanted Resident #3 to follow a liberal renal diet. -She thought the liberal renal diet would be easier for the facility and the resident to follow. -The liberal renal diet would allow for a higher amount of sodium, potassium, and phosphorus than a restrictive renal diet. -She did not want Resident #3 to eat processed foods and meats because of the amount of sodium. -She wanted him to eat more high-quality protein, and she thought the liberal renal diet would promote that for better kidney health. -Resident #3 brought his lunch from the facility to	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 310	Continued From page 158	D 310		

the dialysis clinic and it would include deli meats, cheese and hot dogs; all foods he should not be eating.
-He should not have sausage, hot dogs, potatoes, processed foods and citrus foods.
-His target fluid removal was 71 kilograms and yesterday, 04/28/25, 73 kilograms were removed during his dialysis.

Interview with a personal care aide (PCA) on 04/24/25 at 9:35am revealed:
-There were no residents on a liberal renal diet.
-Resident #3 was not ordered any [therapeutic] diets.
-He went to dialysis three times a week.

Interview with a second PCA on 04/24/25 at 2:20pm revealed:
-None of the residents were on a liberal renal diet.
-She was not told Resident #3 was on a liberal renal diet.
-She did not know what a renal diet or liberal renal diet was.

Interview with a medication aide (MA) on 04/25/25 at 11:45am revealed:
-She helped to pass food and beverages in the dining room.
-There were no residents on a liberal renal diet.
-Resident #3 did not have an order for a liberal renal diet; he was on a regular diet.

Interview with the RCC on 04/28/25 at 9:10am revealed:
-She went into the dining room and observed meals three times a week.
-She thought Resident #3 was on a liberal renal diet.
-It appeared he was served the same foods as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 310	Continued From page 159	D 310		

the other residents.
-Resident #3 went for dialysis three times a week.
-His albumin (indcators usd for liver and kidney functions) looked better from the lab reports that were sent from the RD at the dialysis clinic.
-The dialysis clinic had not sent any after visit reports or instructions to the facility, and she had not asked for one.

Interview with the Administrator on 04/29/25 at 5:40pm revealed:
-None of the residents had an order for a liberal renal diet.
-She was not aware Resident #3 had an order for a liberal renal diet.
-She knew he went to dialysis three times a week.
-She did not know the facility offered a liberal renal therapeutic diet.
-If the facility had a resident with an order for a liberal renal diet, then they should have followed the diet order.
-The DM was responsible for following the diet list and the residents' diet orders.
-She was concerned Resident #3 was on dialysis and was not following a liberal renal diet because it could cause problems with fluids, sodium levels and potassium which could harm his kidneys.

2. Review of Resident #15's current FL-2 dated 10/30/24 revealed diagnoses included type II diabetes mellitus, chronic kidney disease stage 3, and hyperlipidemia.

a. Review of Resident #15's signed physician's orders dated 04/01/25 revealed:
-Resident #15 was ordered a pureed texture diet.
-Pureed texture diets were ordered for resident who had difficulty chewing and swallowing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 310	Continued From page 160 Observation of the lunch meal on 04/22/25 at 12:00pm revealed: -Resident #15 was served pureed spaghetti with meat sauce, pureed broccoli with cheese sauce, and apple sauce. -The pureed spaghetti did not hold shape and was surrounded by a pool of thin liquid. -The pureed broccoli and cheese did not hold shape and was thin and fluid-like and spread across the plate. -Resident #15 ate 100 percent of the apple sauce, and pureed spaghetti, and 25 percent of the broccoli and cheese sauce. -He coughed once and then cleared his throat deep and loudly. Observation of the lunch meal on 04/23/25 at 12:15pm revealed: -Resident #15 was served pureed fish, brussels sprouts, yellow squash, and apple sauce. -The pureed yellow squash did not hold a shape because it was thin, fluid-like, and spread across the section of the plate. -Resident #15 ate 50 percent of the fish, less than 25 percent of the brussels sprouts, 100 percent of the yellow squash and apple sauce. Interview with Resident #15 on 04/24/25 at 12:25pm revealed: -He had trouble with swallowing since he had radiation treatment on his throat for cancer three years ago. -He had not been evaluated by speech therapy for a pureed diet; he was "just put on one by the staff here". -He had not noticed if the food was too thin or too thick. -He usually coughed while eating and drinking and he choked too. -He had no idea how often he coughed; it was not	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 310	Continued From page 161	D 310		

a lot.
-He had thrown up while eating but he could not remember how recently it had been.
-He had not been to the hospital after he threw up while eating.

Interview with Resident #15's primary care provider (PCP) on 04/29/25 at 12:00pm revealed:
-Resident #15 had an order for a pureed diet.
-Pureed food should have the consistency of baby food.
-If a pureed food was too thick or too thin, it could cause choking when swallowing.
-If Resident #15 was vomiting while eating, then he was aspirating.
-She expected the facility to follow her orders.

Interviews with the Dietary Manager (DM) on 04/23/25 at 7:30am and 9:00am revealed:
-The kitchen staff had therapeutic menus they followed when they prepared meals.
-She had a new menu and was on cycle one week three of the menu, but she had not been given the therapeutic diet menu for the week she was using.
-Residents who were ordered a pureed diet were served the same thing the residents on the regular menu were served; the cooks just pureed it.

Interview with the DM on 04/24/25 at 1:20pm revealed:
-She pureed all food for the pureed diets in a blender; whatever she cooked she pureed.
-She pureed food to a baby food consistency.
-She added water to some foods when she used the blender; it depended on the food.
-She pureed Resident #15's food thinner than baby food; she pureed his food next to a liquid consistency because he had problems with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 310	Continued From page 162	D 310		

swallowing.
-Resident #15 did better when his food was more liquid and running over the plate.
-He threw up and coughed when he ate; if his food was thinner, he would do better.
-He threw up last week because he ate off someone else's plate.

Interview with a personal care aide (PCA) on 04/24/25 at 9:35am revealed:
-She was told Resident #15 was served a pureed meal when she was trained.
-Sometimes parts of the meal would be like "water"; when she served his plate.
-She had heard him cough and clear his throat long and loud while eating.
-She had seen Resident #15 throw up while eating.

Interview with a medication aide (MA) on 04/25/25 at 11:45am revealed:
-She helped to pass food and beverages in the dining room.
-Resident #15 was on a pureed diet.
-The pureed food looked correct to her; it did not look too thin or too thick.
-Resident #15 coughed while eating and he threw up in the dining room about a month ago.
-His food got backed up in his throat while eating and he threw it up.

Interview with the Resident Care Coordinator (RCC) on 04/28/25 at 9:10am revealed:
-She went into the dining room and observed meals three times a week.
-She looked at Resident #15's plate to see if he got the right consistency for his puree diet.
-She looked to see if the food was blended, not too thick or too watery [thin].
-If his pureed food was too thin, he could choke.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 310	Continued From page 163	D 310		

-If his food was too thick he could not swallow it.
-He could aspirate, have pneumonia, and end up in the hospital.
-Staff had not reported any coughing or strangling while Resident #15 ate.
-She was not aware he threw up in the dining room a couple of weeks ago.

Interview with the Administrator on 04/28/25 at 4:00pm revealed:
-She walked through the dining room during meals at least once a day.
-She looked at the consistency of Resident #15's pureed diet.
-She did training for the cooks and the DM on 04/21/25 and taught them the correct consistency for a pureed diet.
-The consistency could not be too loose or too thick.
-She did not want a resident to aspirate while eating.
-She taught the cooks to blend the food down to puree and to add thickener or water to get a smooth consistency.
-She was not aware Resident #15 had vomited while eating and drinking.
-She was concerned because if he had vomited, then he could have aspirated.

b. Review of Resident #15's signed physician's orders dated 04/01/25 revealed:
-Resident #15 had an order for a thickened liquid diet.
-There was no consistency of the thickened liquid diet listed.

Observation of the lunch meal on 04/23/25 at 12:15am revealed:
-Resident #15 was served an iced water and pink lemonade with ice; neither beverage was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 310	Continued From page 164 thickened. -Resident #15 drank 50 percent of his water and lemonade. Observation of the dinner meal on 04/23/25 at 5:00pm revealed: -Resident #15 was served water and lemonade with ice; neither ws thickened. -He drank 50 percent of each beverage. Observation of the kitchen on 04/23/25 at 5:59pm revealed: -There was a box of instant food and liquid thickener packets on a shelf in the kitchen. -The label on the thickener packet had for swallowing difficulties on it. -Each packet was 5.5gms (0.19oz). -The label had for nectar thick consistence when mixed with water, coffee, and clear juices, and honey thick when mixed with orange juice and milk. -The directions on the thickener packet were to add one packet to 4oz of liquid, stir for approximately 15 seconds until dissolved and allow 1 to 4 minutes for product to reach desired thickness. Interview with Resident #15's PCP on 04/29/25 at 12:00pm revealed: -Resident #15 had an order for a pureed diet with honey thickened liquids. -Honey thickened liquids should not be served with ice because it diluted the liquid and thinned the consistency. -If a honey thickened liquid was too thin, it could cause choking when swallowing. -If Resident #15 was vomiting while drinking then he was aspirating. -She expected the facility to follow her orders.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 310	Continued From page 165 Interview with Resident #15 on 04/24/25 at 12:25pm revealed: -He had trouble with swallowing since he had radiation treatment on his throat for cancer three years ago. -He did not know about an order for thickened liquids and he did not know why he had an order for thickened liquids. -His beverages were not always thickened. -His beverages always had ice in them. -He usually coughed while eating and drinking and he choked too. -He had no idea how often he coughed; it was not a lot. -He had thrown up while eating and drinking but he could not remember how recently it had been. -He had not been to the hospital after he threw up while drinking. Interviews with the DM on 04/23/25 at 7:30am and 9:00am revealed: -Resident #15 was the only resident ordered a thicken liquid. -She did not know the consistency of the thicken liquid. Interview with the DM on 04/24/25 at 1:20pm revealed: -The medication aides (MA) thickened the liquids. -The kitchen staff always put ice in Resident #15's beverages. -She did not know ice was not supposed to be added to beverages that were thickened. -She did not know if the MAs took the ice out of Resident #15's beverages when they thickened them. Interview with a PCA on 04/24/25 at 9:35am revealed: -She was told during her training that Resident	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 310	Continued From page 166 #15 got thicken liquids. -The beverages were poured in the kitchen and brought out to the dining room on a cart. -The beverages already had ice in them when they came from the kitchen. -She was told to put one package of thickener per beverage and stir it up; she was not told to wait to serve the beverage after she added the thickener. -She had heard Resident #15 cough before, and she had seen him throw up at meals. -One day last week he was drinking, then he started to cough and he threw up. -Resident #15 would clear his throat and it would be long, loud and deep. Interview with a MA on 04/25/25 at 11:45am revealed: -She helped to pass food and beverages in the dining room. -Resident #15 had an order for thickened liquids. -The kitchen staff poured the drinks, and the drinks always had ice in them. -The MAs or the PCAs thickened the drinks with the thicken packets from the kitchen. -The previous RCC showed her how to thicken a drink. -She poured the thickened packet into the drink and stirred it up; she did not have to wait any because the drink got thick quickly. -She left the ice in the drinks when she thickened them, so they did not get hot. -Resident #15 coughed a lot but he did not cough when he drank. -He threw up in the dining room last month. Interview with the RCC on 04/28/25 at 9:10am revealed: -She went into the dining room and observed meals three times a week. -She did not look at Resident #15's thicken liquid.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 310	Continued From page 167 -She thought the kitchen staff prepared the thickened liquid. -Thickened liquids should not have ice in them because as the ice melted it would change the consistency of the beverage; it thinned the beverage. -If the beverages were not made to the correct consistency, Resident #15 could be at risk of strangling while drinking. -Staff had not reported any coughing or strangling while Resident #15 drank. -She was not aware he threw up in the dining room a couple of weeks ago. -He could aspirate, have pneumonia and end up in the hospital. Interview with the Administrator on 04/28/25 at 4:00pm revealed: -She walked through the dining room during meals at least once a day. -The directions for thickening liquids were on the thickening packet. -The cooks should have been thickening Resident #15's liquids in the kitchen. -The cooks had been trained on how to properly thicken liquids and knew what they were doing. -The staff were not allowed to put ice in thickened liquids. -Melted ice would thin the liquid and it would not be the right consistency anymore. -She was not aware Resident #15 had vomited while eating and drinking. -She was concerned because he had thrown up. 3. Review of the diet order list dated 04/01/25 posted in the special care unit (SCU) revealed 4 residents were to be served nutritional supplements three times daily with meals, for a total of 12 supplements daily.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 310	Continued From page 168 Review of assisted living (AL) residents diet orders revealed 3 residents diet order was for nutritional supplements three times daily with meals, for a total of 9 supplements daily. Observation of the kitchen on 04/22/25 at 9:19am revealed there were no nutritional supplements in the reach in freezers or the reach in coolers. Observation of the breakfast meal service in the AL and SCU on 04/22/25 at 8:22am revealed no nutritional supplements were served. Observation of the lunch meal service AL and SCU on 04/22/25 at 12:06pm revealed no nutritional supplements were served. Observation of the food delivery on 04/22/25 at 11:50am revealed one case of 50 nutritional supplements were delivered; the nutritional supplements were frozen and needed to be thawed before they could be served. Observation of the kitchen on 04/24/25 at 8:12am revealed there was a case of 50 nutritional supplements with 29 remaining in the case. Review of the purchase orders for nutritional supplements revealed: -On 04/08/25, no nutritional supplements were delivered. -On 04/11/25, 04/15/25, and 04/22/25 one case of 50 nutritional supplements were delivered. Based on reviews of the diet lists for both the AL and SCU residents, it was determined one case of nutritional supplements would have lasted 2.38 days and the facility need to have ordered 3 cases of nutritional supplements per week.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 310	Continued From page 169 a. Review of Resident #3's current FL-2 dated 07/22/24 revealed diagnoses included hypertension, chronic kidney disease, congestive heart failure, diabetes mellitus type 2, bilateral leg edema, schizophrenia, and kidney failure. Review of Resident #3's signed physician's orders dated 04/01/25 revealed there was an order for a nutritional supplement three times daily with meals. Review of the AL diet list revealed Resident #3 was to be served a nutritional supplement 3 times daily with meals. Observation of the breakfast meal service and the lunch meal service on 04/22/25 revealed Resident #3 was not served a nutritional supplement. Review of Resident #3's April 2025 electronic medication administration record (eMAR) from 04/01/25-04/22/25 revealed: -There was an entry to administer nutritional supplements three times daily with meals. -There was documentation that a nutritional supplement was served three times daily with meals from 04/01/25-04/22/25. Interview with Resident #3 on 04/24/25 at 1:59pm revealed: -He was served a nutritional supplement once a day. -He did not ask for the nutritional supplement; the staff "just gave it to" him. b. Review of Resident #4's FL-2 dated 01/28/25 revealed: -Diagnoses included hypertension and dementia	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 310	Continued From page 170	D 310		

with behavioral disturbance.
-There was an order for a nutritional supplement three times daily with meals.

Review of Resident #4's signed physician's orders dated 04/01/25 revealed:
-There was an order for a nutritional supplement three times daily with meals.
-There was an order for monthly weights.

Review of Resident #4's care plan dated 01/28/25 revealed:
-Resident #4 required supervision with eating.
-Resident #4 was totally dependent on staff for food preparation and serving.

Review of the diet order list dated 04/01/25 posted in the SCU revealed Resident #4 was to be served a nutritional supplement three times daily with meals.

Observation of the breakfast meal service and the lunch meal service on 04/22/25 revealed Resident #4 was not served a nutritional supplement.

Review of Resident #4's April 2025 eMAR from 04/01/25-04/22/25 revealed:
-There was an entry to administer nutritional supplements three times daily with meals.
-There was documentation that a nutritional supplement was served three times daily with meals from 04/01/25-04/22/25.

Review of Resident #4's weights from January 2025-April 2025 revealed:
-Resident #4 refused weights in January 2025 and February 2025.
-Resident #4 weighed 136.9 on 03/31/25 and 136 on 04/25/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 310	Continued From page 171 -Resident had a 0.7% weight change. Telephone interview with Resident #4's family member on 04/28/25 at 3:13pm revealed: -Resident #4 complained about not getting enough to eat. -Resident #4 had always been on the "slim side," but not "this slim." Interview with a medication aide (MA) on 04/24/25 at 8:12am revealed Resident #4 ate extra "good", he cleaned his plate. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable. c. Review of Resident #7's FL-2 dated 02/01/25 revealed: -Diagnoses included mental retardation, type 2 diabetes, and hypertension. -There was an order for a nutritional supplement three times daily with meals. Review of Resident #7's signed physician's orders dated 04/01/25 revealed: -There was an order for a nutritional supplement three times daily with meals. -There was an order for monthly weights. Review of Resident #7's care plan dated 04/01/25 revealed: -She was totally dependent on staff for eating. -She was totally dependent on staff for food preparation and serving. Review of the diet order list dated 04/01/25 posted in the SCU revealed Resident #7 was to be served a nutritional supplement three times daily with meals.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 310	Continued From page 172 Observation of the breakfast meal service and the lunch meal service on 04/22/25 revealed Resident #7 was not served a nutritional supplement. Review of Resident #7's April 2025 eMAR from 04/01/25-04/22/25 revealed: -There was an entry to administer nutritional supplements three times daily with meals. -There was documentation that a nutritional supplement was served three times daily with meals from 04/01/25-04/22/25. Review of Resident #7's weights from January 2025-April 2025 revealed: -Resident #7 weighed 115 on 01/05/25 and 02/05/25, 112 on 03/05/25 and and 111 on 04/05/25. -Resident #7 had a 3.5% weight change. Interview with a MA on 04/24/25 at 8:12am revealed Resident #7 sometimes ate good and sometimes did not; she would spit her food out. Based on observations, interviews, and record reviews, it was determined Resident #7 was not interviewable. Attempted telephone interview with Resident #7's family member on 04/29/25 at 11:49am was unsuccessful. d. Review of Resident #8's FL-2 dated 09/12/24 revealed diagnoses included dementia, vitamin D deficiency, non-insulin dependent diabetes mellitus, and dyslipidemia. Review of Resident #8's signed physician's orders dated 04/01/25 revealed:	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 310	Continued From page 173 -There was an order for a nutritional supplement three times daily with meals. -There was an order for monthly weights. Review of Resident #8's care plan dated 04/01/25 revealed: -He required limited assistance from staff for eating. -He was totally dependent on staff for food preparation and serving. Review of the diet order list dated 04/01/25 posted in the SCU revealed Resident #8 was to be served a nutritional supplement three times daily with meals. Observation of the breakfast meal service and the lunch meal service on 04/22/25 revealed Resident #8 was not served a nutritional supplement. Review of Resident #8's April 2025 eMAR from 04/01/25-04/22/25 revealed: -There was no entry to administer nutritional supplements three times daily with meals. -There was no documentation that a nutritional supplement was served three times daily with meals from 04/01/25-04/22/25. Review of Resident #8's weights from January 2025-April 2025 revealed: -Resident #8 weighed 172.8 on 01/01/25, 173 on 02/05/25, 172 on 03/05/25, and 130 on 04/05/25. -Resident #8 had a 24.9% weight change. Interview with a personal care aide (PCA) on 04/28/25 at 4:15pm revealed: -She asked two different MAs who were to be served a nutritional supplement when she started working at the facility.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 310	Continued From page 174 -She named 4 residents whom she served nutritional supplements; Resident #8 was not one of the 4 named residents. -She did not know Resident #8 was supposed to be served a nutritional supplement. Interview with a MA on 04/24/25 at 8:12am revealed: -Resident #8 ate"pretty good." -Every once in a while, he would not eat. Interview with the facility's contracted primary care provider (PCP) on 04/29/25 at 11:58am revealed: -She did not know about Resident #8's weight loss until today, 04/29/25. -She also was notified today, 04/29/25, that Resident #8 may not have been receiving his nutritional supplement as ordered. -She was concerned he was not receiving the protein he needed to maintain his weight and muscle mass. Based on observations, interviews, and record reviews, it was determined Resident #8 was not interviewable. Attempted telephone interview with Resident #8's family member on 04/29/25 at 11:51am was unsuccessful. e. Review of Resident #9's FL-2 dated 02/18/25 revealed: -Diagnoses included dementia, rheumatoid arthritis, and hypertension. -There was an order for a nutritional supplement three times daily with meals. Review of Resident #9's signed physician's orders dated 04/01/25 revealed:	D 310		

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D 310	Continued From page 175 -There was an order for a nutritional supplement three times daily with meals. -There was an order for monthly weights. Review of Resident #9's care plan dated 02/04/25 revealed: -Resident #9 required limited assistance from staff for eating. -Resident #9 was totally dependent on staff for food preparation and serving. Review of the diet order list dated 04/01/25 posted in the SCU revealed Resident #9 was to be served a nutritional supplement three times daily with meals. Observation of the breakfast meal service and the lunch meal service on 04/22/25 revealed Resident #9 was not served a nutritional supplement. Observation of the lunch meal service on 04/23/25 at 12:30pm revealed: -Resident #9 did not eat her lunch meal. -Resident #9 was not served a nutritional supplement. Interview with a PCA on 04/28/25 at 4:15pm revealed: -She asked two different MAs who were to be served a nutritional supplement when she started working at the facility. -She named 4 residents whom she served nutritional supplements; Resident #9 was not one of the 4 named residents. -She did not know Resident #9 was supposed to be served a nutritional supplement. Interview with the Special Care Unit Coordinator (SCC) on 04/25/25 at 10:49am revealed:	D 310		

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D 310	Continued From page 176 -She was not aware that Resident #9 had not eaten her meal. -She did not know that Resident #9's nutritional supplement was served to another resident on 04/23/25. Interview with a MA on 04/24/25 at 8:12am revealed: -Resident #9 sometimes ate "good" and sometimes did not. -Sometimes she would not eat anything. Review of Resident #9's April 2025 eMAR from 04/01/25-04/22/25 revealed: -There was an entry to administer nutritional supplements three times daily with meals. -There was documentation that a nutritional supplement was served three times daily with meals from 04/01/25-04/22/25. Review of Resident #9's weights from January 2025-March 2025 revealed: -Resident #9 weighed 164.2 on 01/05/25, 166 on 02/05/25, and 164 on 03/05/25. -Resident #9 had a 1.2% weight change. Observation of Resident #9's weight on 04/25/25 at 11:23am revealed: -Resident #9's weight was 197.9 in a wheelchair. -Resident #9's wheelchair weighed 35.3 -Resident #9's weight was calculated as 162.6. Based on observations, interviews, and record reviews, it was determined Resident #9 was not interviewable. Attempted telephone interview with Resident #9's family member on 04/25/25 at 12:12pm was unsuccessful.	D 310		

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D 310	Continued From page 177 f. Review of Resident #14's current FL-2 dated 10/30/24 revealed diagnoses included hypertension, anxiety, blindness in both eyes, coronary artery disease, hyperlipidemia, history carotid stenosis and chronic obstructive pulmonary disease (COPD). Review of Resident #14's signed physician's order dated 04/01/25 revealed there was an order for a nutritional supplement scheduled three times daily with meals. Review of Resident #14's April 2025 eMAR from 04/01/25-04/22/25 revealed: -There was an entry to administer nutritional supplements three times daily with meals. -There was documentation that a nutritional supplement was served three times daily with meals from 04/01/25-04/22/25. Review of Resident #14's weights from January 2025-April 2025 revealed: -Resident #14 weighed 90.3 on 01/05/25, 88 on 02/05/25, 87.4 on 03/05/25, and 86.5 on 04/05/25. -Resident #14 had a 4.2% weight change. Observation of the breakfast meal on 04/22/25 at 8:00am revealed Resident #14 was not administered a nutritional supplement. Interview with Resident #14's PCP on 04/29/25 at 12:50pm revealed: -Resident #14 had a diagnosis of cancer. -Resident #14 was ordered a supplement three times a day to help her maintain her weight. -She expected the facility to follow her orders. Interview with Resident #14 on 04/25/25 at 11:25am revealed:	D 310		

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	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 310	Continued From page 178 -Sometimes she was given a supplement when she was eating. -She did not like the taste, but she would drink the supplement when it was given to her. -She did not know who gave her the supplement. -She did not get it every day or at every meal. -She did not know how often she was supposed to get a supplement. -She did not know the last time she got a supplement. g. Review of Resident #19's FL-2 dated 06/10/24 revealed: -Diagnoses included vascular dementia without behavioral disturbance and epilepsy. -There was an order for monthly weights. Review of Resident #19's signed physician's orders dated 04/01/25 revealed: -There was an order for a nutritional supplement three times daily with meals. -There was an order for weekly weights. Review of Resident #19's care plan dated 04/01/25 revealed: -He required supervision with eating. -He was totally dependent on staff for food preparation and serving. Observation of the breakfast meal service and the lunch meal service on 04/22/25 revealed Resident #19 was not served a nutritional supplement. Review of Resident #19's April 2025 eMAR from 04/01/25-04/22/25 revealed: -There was an entry to administer nutritional supplements three times daily with meals. -There was documentation that a nutritional supplement was served three times daily with	D 310		

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ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 310	Continued From page 179 meals from 04/01/25-04/22/25. Review of Resident #19's weekly weights for April 2025 revealed a weight of 146 on 04/02/25 and 04/09/25 and 145.3 on 04/16/25 and 04/23/25. Interview with Resident #19 on 04/24/25 at 1:56pm revealed: -He was served a nutritional supplement once a day if he asked for it. -He was never served a nutritional supplement more than once a day. _____ Interview with a MA on 04/24/25 at 8:12am revealed: -There were days when a nutritional supplement was not available to be served, but it had been a while. -She thought there were no nutritional supplements available to be served on Tuesday, 04/22/25, at breakfast, but she could not recall lunch on 04/22/25. -When she signed off on medications served, she forgot to mark off that there were no nutritional supplements available. Interview with a second MA on 04/24/25 at 12:43pm revealed: -She ordered food for the facility. -She ordered nutritional supplements one week at a time, Tuesday-Tuesday. -She usually ordered a case of 75 nutritional supplements and a second case of 50. -There were some weeks nutritional supplements were left over, but not every week. -She knew "75 + 50 were enough." Interview with a third MA on 04/28/25 at 5:49pm revealed: -If the dietary staff had a nutritional supplement	D 310		

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D 310	Continued From page 180	D 310		

available, they put it out to be served.
-There were no nutritional supplements available "a week or two ago."
-She let the dietary staff know when she did not see the residents served a nutritional supplement.
-Once in a while, she would go into the dining room, and there would be no nutritional supplements served.

Interview with a dietary aide on 04/24/25 at 12:52pm revealed:
-The nutritional supplements ran out on Monday, 04/21/25.
-There were a couple of nutritional supplements available at the breakfast meal service on Monday, 04/21/25.
-He told the Dietary Manager (DM) and someone in the SCU, but he did not recall who, that there were no nutritional supplements, but they knew the food delivery was scheduled for Tuesday, 04/22/25.

Interview with the DM on 04/24/25 at 12:57pm revealed:
-A [named] staff member did the food order weekly.
-The [named] staff member knew how many nutritional supplements to order each week because she had been doing the order "a long time."
-The nutritional supplements were kept in the refrigerator; they were never kept in the freezer.
-She did not recall the [named] staff member asking her if there were any nutritional supplements in the kitchen when she ordered food for the delivery on 04/23/25.
-She did not know the nutritional supplements "ran out" on 04/21/25.

Interview with the Resident Care Coordinator

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D 310	Continued From page 181 (RCC) on 04/29/25 at 9:49am revealed: -She was not aware that there were days when there was no nutritional supplement available to be served. -She was told if there were no nutritional supplements available, to go purchase some. -She expected to be notified if there were no nutritional supplements in the facility. Interview with a PCA on 04/28/25 at 5:32pm revealed: -If a nutritional supplement was not on the food cart, she would ask the dietary staff. -There were a few times there were no nutritional supplements on the cart to be served, but when she asked the dietary staff, they gave her what was needed. Interview with the Administrator on 04/29/25 at 4:53pm revealed: -She expected residents to receive supplements as ordered. -If there were no nutritional supplements available to be served, she expected to be notified so she could notify the PCP and order additional nutritional supplements. -She was concerned that the residents who had orders for nutritional supplements did not get the nutritional supplements when they were ordered for a reason. Telephone interview with the facility's contracted PCP on 04/25/25 at 9:53am revealed: -She ordered a nutritional supplement for residents who needed more protein. -Protein played a crucial role in building and maintaining muscle mass, which was important for overall health, including preventing dehydration, supporting weight management, and even influencing medication absorption.	D 310		

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D 310	Continued From page 182 -Muscle mass was also important for fall prevention. -She expected the nutritional supplements to be served as ordered. _____ The facility failed to ensure therapeutic diets were served as ordered for a resident who was ordered a liberal renal diet, who was on dialysis for chronic kidney disease and was served foods that were to be reduced or excluded from a liberal renal diet (#3) and a resident who had difficulty with swallowing and was ordered a pureed diet but was served pureed foods at the incorrect consistency and honey thicken liquids but was served thin liquids or thickened liquids with ice (#15). There were 7 residents who were not served nutritional supplements as ordered by their PCP (#3, #4, #7, #8, #9, #14, and #19) putting the residents at risk for weight loss, including Resident #8 who had more than a 30-pound documented weight loss from January 2025-April 2025. The facility's failure resulted in significant risk for physical harm, which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/26/25 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 29, 2025.	D 310		
D 322	10A NCAC 13F .0906 (b) Other Resident Care And Service 10A NCAC 13F .0906 Other Resident Care And Services	D 322		

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	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 322	Continued From page 183 (b) Mail. (1) Residents shall receive their mail promptly and it shall be unopened unless there is a written, witnessed request authorizing management staff to open and read mail to the resident. This request shall be recorded on Form DSS-1865, the Resident Register or the equivalent; (2) Outgoing mail written by a resident shall not be censored; and (3) Residents shall be encouraged and assisted, if necessary, to correspond by mail with close relatives and friends. Residents shall have access to writing materials, stationery and postage and, upon request, the home shall provide such items at cost. It is not the home's obligation to pay for these items. This Rule is not met as evidenced by: Based on interviews and observations, the facility failed to ensure the residents received their mail promptly and unopened. The findings are: Observation of a resident's mail in her room on 04/23/25 at 10:50am revealed: -She had multiple opened letters and envelopes on her bedside table. -Each opened letter had an opened envelope with it. -There was one letter from a physician's office about a scheduled appointment that did not have an envelope with it. Interview with the resident on 04/23/25 at 10:50am revealed: -She was very upset because the Administrator had opened a letter that was addressed to her.	D 322		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 322	Continued From page 184 -She knew of a letter from her physician about an appointment and lab work that were scheduled that the Administrator had opened. -She knew the Administrator opened the letter because the letter was not in an envelope when it was handed to her on the day of the scheduled appointment. -She kept the letters and envelopes together after she opened them. Interview with the Maintenance Director on 04/28/25 at 4:05pm revealed he got the mail out of the facility's mailbox every day and gave it to the Administrator. Interview with the Resident Care Coordinator (RCC) on 04/24/25 at 3:50pm revealed: -The Administrator opened the residents' mail. -When a resident's mail came addressed to the resident at the facility, the Administrator opened it. -The Administrator had to open mail for some of the residents. -One of the resident's appointment schedule came by mail and the Administrator had to open it so she would know about the upcoming appointments. Interview with the Administrator on 04/28/25 at 4:20pm revealed: -She only opened residents' mail if it related to the Department of Social Services. -When there was mail for the facility through the resident, like a payment, she would open it. -She would open the mail when it was addressed to the facility and the resident, but the resident was listed second. -For example, mail from the Social Security Administration was addressed to the facility for a named resident. -If the mail was only addressed to the resident,	D 322		

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	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 322	Continued From page 185 she did not open it and gave it to the resident. -Residents complained to her about the previous Administrator opening their mail without permission. -Residents had the right to privacy and to open their own mail.	D 322		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations and interviews, the facility failed to ensure residents were treated with respect, consideration, and dignity related to a resident requesting anxiety and pain medications (#2), the residents missing meals if they did not go to the dining room, and the residents not having toilet paper in their bathrooms. The findings are: 1. Review of Resident #2's current FL-2 dated 01/28/25 revealed diagnosis included dysphagia, chronic pain, hyperlipidemia, anxiety, muscle weakness, edema, and chronic obstructive pulmonary disease (COPD). Observation of Resident #2 on 02/28/25 at 5:30pm revealed: -Resident #2 was in the main lobby of the facility. -She returned to the facility and complained of	D 338		

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	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 338	Continued From page 186	D 338		

pain after a medical procedure.
-She became very upset and asked for medication for her pain and for her anxiety.
-She was told she did not have an as needed medication (PRN) medication for her anxiety and could not take anything for her anxiety or her pain until an hour before her scheduled medication time of 8:00pm.
-She told the medication aide (MA) she had not had her scheduled 2:00pm lorazepam (used to treat anxiety) or oxycodone (used to treat pain) because she was out of the facility and asked if she could be administered the medication now.
-Resident #2 asked the MA to call her primary care provider (PCP) and ask them if she could have her scheduled medications now since she had missed her scheduled 2:00pm medications.
-She was told by staff that it was after 5:00pm and the PCP would not answer and would not get the message.
-Resident #2 began to raise her voice, cried out for help and begged for something to relieve her anxiety and pain.
-She requested the staff to call 911 to send her out or to "please" contact her PCP.
-She was administered acetaminophen (used to treat pain) for her pain but was told there were no PRN medications for her anxiety.
-She told the MA that the acetaminophen would not help her chronic pain but she would take it anyway.

a. Review of Resident #2's discharge notes from the Veteran's Affairs (VA) hospital dated 03/03/25 revealed there was an order for lorazepam (used to treat anxiety) 0.5mg take one-half tablet daily PRN for anxiety.

Interview with Resident #2 on 04/28/25 at 5:40pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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) COMPLETE DATE
D 338	Continued From page 187 -She had anxiety because she was out of the facility for a medical procedure and had missed her scheduled dose of anxiety medication. -Her anxiety was so elevated, she had tinnitus (buzzing or ringing sounds in the ears) so loud she could not think. -It sounded like a "freight train" was in her ears and going through her. -The MA refused to give her anything for her anxiety. Interview with Resident #2 on 04/29/25 at 8:05am revealed: -She did not sleep the night before, 04/28/25, because of anxiety. -She was given her scheduled dose of lorazepam, but she had so much anxiety it took her a while to feel calm. -She did not feel herself and she felt "off" today, 04/29/25 because she did not sleep. Interview with a MA on 04/28/25 at 5:40pm revealed: -She could not administer Resident #2 her scheduled medications because it was too early. -Resident #2 did not have a PRN medication for anxiety. -She did not call the PCP; the Resident Care Coordinator (RCC) had to call the PCP to ask about medications she could give Resident #2. Interview with Resident #2's PCP on 04/29/25 at 12:10pm revealed: -She had not received a message last night, 04/28/25, about Resident #2's medications or a request to administer them early. -Resident #2 had an order for lorazepam PRN the MA could have given it to the resident last night for her anxiety.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 338	Continued From page 188	D 338		

Interview with the RCC on 04/29/25 at 3:21pm revealed:
-She was not aware Resident #2 had an order for lorazepam PRN.
-They should have given her the lorazepam for her anxiety.
-She had only heard about Resident #2's anxiety that morning.

Interview with the Administrator on 04/29/25 at 4:35pm revealed:
-She was at the facility last night and no one spoke to her about Resident #2.
-She spoke to Resident #2 around 7:30pm or 8:00pm last night and the resident did not say anything to her about medications.
-If Resident #2 had a PRN medication for anxiety, she expected the MAs to administer it.

b. Review of Resident #2's current FL-2 dated 01/28/25 revealed there was an order for oxycodone (used to treat pain) 10mg scheduled three times daily.

Interview with Resident #2 on 04/28/25 at 5:40pm revealed:
-She was experiencing pain, because she was out of the facility for a medical procedure and had missed her scheduled dose of oxycodone.
-The MA only offered her acetaminophen for her pain; she knew the acetaminophen would not help because she was experiencing pain from her procedure.

Interview with Resident #2 on 04/29/25 at 8:05am revealed:
-She did not sleep the night before, 04/28/25 because of her pain from her procedure earlier in the day and her chronic pain.
-She was given her scheduled dose of oxycodone

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 338	Continued From page 189	D 338		

last night, 04/28/25, but by the time she was administered the oxycodone, she was in so much pain it was too late.
-The acetaminophen she was administered the night before did not help her chronic pain.
-She did not feel herself and she felt "off" today, 04/29/25, because she did not sleep.
-She did not know why the staff would not call her PCP to ask if she could have her scheduled medications early.

Interview with a MA on 04/28/25 at 5:40pm revealed:
-She could not administer Resident #2 her scheduled medications because it was too early.
-Resident #2 had an order for acetaminophen PRN so that was what she gave her for her pain.
-The MAs did not have a way to contact the PCP after hours.
-She did not call the PCP; the Resident Care Coordinator (RCC) had to call the PCP to ask about medications she could give Resident #2.
-She would administer Resident #2's scheduled 8:00pm medications at 7:00pm; she only had about an hour to wait.

Interview with a MA on 04/29/25 at 8:42am revealed:
-She would reach out to the RCC to let her know if a resident needed the PCP.
-She did not have a way to reach out to the PCP directly.

Interview with Resident #2's PCP on 04/29/25 at 12:10pm revealed:
-She had not received a message last night, 04/28/25, about Resident #2's medications or a request to administer of her scheduled pain medications earlier than scheduled..
-She could have gone over the list of medications

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 338	Continued From page 190 with the MA, and she could have decided which ones Resident #2 could have been administered before the scheduled administration times, including her medications for her pain. -She did not find out about Resident #2 until she came to the facility that morning, 04/29/25. Interview with the RCC on 04/29/25 at 3:21pm revealed: -One of the staff should have reached out to the PCP for Resident #2 last night, 04/28/25, about administering her medications. -To say it was after 5:00pm was not acceptable. -The MAs could reach out the to PCP with questions; there was always someone on call that could have helped the MA. -There was a system the MAs could communicate with a physician through, and the MAs had access to it. -She heard about Resident #2 being in pain this morning, 04/29/25. -If she had known about it last night she would have contacted the PCP. Interview with the Administrator on 04/29/25 at 4:35pm revealed: -She had not been told anything about Resident #2 and her pain the night before, 04/28/25. -The staff could always reach the PCP or someone at the PCP's office through the telehealth system. -She was at the facility last night and no one asked her to reach out to the PCP. -There were no calls to 911 the night before. -She spoke to Resident #2 around 7:30pm or 8:00pm last night and the resident did not say anything to her. -She expected the staff to have reached out to Resident #2's PCP if she needed a medication.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 338	Continued From page 191 2. Observations of resident bathrooms on 04/22/25 at various times from 8:25am to 10:15am revealed: -Resident rooms 26 and 27 shared a bathroom; there were three residents in room 26 and one resident in room 27. -At 8:25am and 10:10am, resident bathrooms 10, 11, 12 and the resident bathroom shared by rooms 26 and 27 did not have toilet paper. -At 10:15am, resident bathrooms 10, 11, 12 and the resident bathroom shared by rooms 26 and 27 each had a single roll of toilet paper. Observation of a supply closet on 04/24/25 at 2:24pm revealed there were 32 rolls of toilet paper on a shelf. Observation of the Special Care Coordinator (SCC) office on 04/24/25 at 2:25pm revealed: -There were two unopened cases of toilet paper in a cabinet; each case had 96 rolls. -There was an opened case of toilet paper on the floor with 86 rolls. Interview with a resident on 04/22/25 at 8:45am revealed: -The bathrooms did not always have toilet paper. -She had to ask the staff for toilet paper if she ran out. -The staff always had toilet paper to give her. Interview with a second resident on 04/22/25 at 10:00am revealed: -She ran out of toilet paper often. -About two weeks ago she asked for toilet paper, and it took two days to get some. -The staff only gave one roll at a time and women used a lot of toilet paper, so they ran out more frequently. -She just pulled up her adult brief and did not	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 338	Continued From page 192 wipe clean when she did not have toilet paper to use. Interview with a third resident on 04/22/25 at 2:28pm revealed: -She had to go without toilet paper a lot. -She had saved her napkin from her meals to use when out of toilet paper. -She had used her hand to wipe herself clean before and washed them in the sink afterwards. -She had been without toilet paper for a few days. -The staff would say they would get her toilet paper when she told them she was out, but they seemed to never bring it. Interview with a personal care aide (PCA) on 04/28/25 at 12:00pm revealed: -When residents told her they were out of toilet paper she would tell a medication aide (MA) or the housekeeper. -She did not have a key to the storage closet to get toilet paper. Interview with a medication aide (MA) on 04/25/25 at 11:45am revealed the MAs did not have anything to do with restocking or getting toilet paper for the residents; it was the housekeepers' job. Interview with a housekeeper on 04/24/25 at 9:05am revealed: -He put toilet paper in the residents' bathrooms every day. -Sometimes the PCA's put toilet paper in the residents' bathrooms. -He used to leave 2 rolls of toilet paper in the bathrooms but now he only left one because the residents would clog the toilets. -He did not know how long he had been leaving one roll of toilet paper.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 338	Continued From page 193 -The residents were hiding toilet paper, and they would waste it. -He would wait until the roll of toilet paper in the bathroom was less than half used and he would swap it out for a new roll. -He did rounds early in the morning when he first got to work and he would look in the bathrooms for toilet paper. -He was training a new housekeeper on 04/22/25 and it changed his routine so there was no toilet paper in some of the bathrooms. -If a resident needed toilet paper they could go to the PCA to get the toilet paper. -Extra toilet paper was kept in the SCC office for convenience so the PCAs would have access to it when he was not there. -The last time the toilets had been clogged was last week; there were multiple backups in multiple toilets. Interview with the Resident Care Coordinator (RCC) on 04/28/25 at 9:10am revealed: -The housekeeper was responsible for keeping toilet paper in the residents' bathrooms. -If a resident told her they needed toilet paper she would let the housekeeper know. -The supply closet where the toilet paper was stored was always locked and she did not have a key. -The Maintenance Director and the housekeeper had keys to the supply closet. -She would look on the housekeeping cart and take toilet paper rolls off the cart to give to a resident if they requested some. -The toilet paper in the residents' bathrooms should be replenished every day and staff should have access to extra rolls. -The residents should never have to go without toilet paper.	D 338		

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	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 338	Continued From page 194 Interview with the Administrator on 04/28/25 at 4:00pm revealed: -The residents did not have toilet paper because they used it all up at one time. -The residents used the toilet paper and stopped up the toilets. -She walked the hallways every day and went into the residents' rooms every day. -Housekeeping staff made sure the residents had toilet paper. -The residents could always ask for toilet paper. -Sometimes a couple of the female residents would ask for more toilet paper and she always got it for them. -None of the residents had complained to her about having to use their hands or having to pull up their brief without using toilet paper. -The MAs had keys to the supply closet where the toilet paper was stored and could give it to a resident if requested. 3. Observation of the lunch meal in the Assisted Living (AL) on 04/22/25 revealed there were 36 residents in the dining room. Observation of the breakfast meal in the AL on 04/23/25 at 7:30am revealed there were 33 residents in the dining room and observation of the dining room in the AL on 04/23/25 at 5:00pm revealed there were 33 residents in the dining room. Observations of residents on 04/23/25 at 5:00pm to 5:20pm revealed: -There was a resident asleep on her bed in her room and she did not go to a meal. -There was a resident in his room on his bed asleep. -There was a resident outside in a wheelchair, and he did not go to eat.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 338	Continued From page 195 Interview with a resident on 04/23/25 at 5:20pm revealed: -Her roommate only went to meals a couple of times a week. -She stayed in the room and did not get up. -Staff did not always ask her roommate if she wanted to eat. -Her roommate slept a lot. -She had not seen staff bring her roommate food to the room. -If the residents did not go to the dining room to eat, they did not eat. Interview with a second and third resident on 04/28/25 at 2:45pm revealed: -Sometimes staff did not tell them it was time to eat. -They did not have a clock that worked so they did not know what time it was for meals. -If they did not go to the dining room to eat they missed the meal and did not eat anything. -They missed lunch one time and were told they had to wait until dinner to eat; they did not recall when. -Now they took turns going into the hall and asking if it was time to eat; they wanted to be sure they did not miss any more meals. Interview with a fourth resident's family member on 03/11/25 at 12:00pm revealed: -The resident went some days without food because he did not leave the room. -If he did not go to the dining room for meals, no one brought it to him or made sure he ate. Interview with a fifth resident on 04/22/25 at 8:46am revealed: -Today, 04/22/25, was the first day her breakfast had been brought to her room since she had	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 338	Continued From page 196	D 338		

been at the facility.
-If she do not go to the dining hall at mealtimes, she would not eat.
-No one came to tell her it was mealtime.

Interview with a sixth resident on 04/25/25 at 3:04pm revealed:
-The staff usually came down the hallway about an hour before breakfast to tell the residents to wake up.
-The staff used to yell down the hallway.
-If he did not go up the hallway to a meal, no one came to get him when it was time to eat.

Interview with a seventh resident on 04/25/25 at 3:21pm revealed:
-If staff did not come to get him for meals, he would peek out in the hallway.
-Staff came to get him about 60-70 percent of the time but it depended on who was working.

Interview with the facility's contracted primary care provider (PCP) on 04/29/25 at 12:50pm revealed:
-The facility did not notify her when a resident missed a meal.
-If a resident missed 2 or more consecutive meals she wanted to be notified.
-Residents who missed more than 2 consecutive meals could have underlying issues related to stomach issues, constipation, or a behavior like self-harm.
-Residents needed to eat consistently to maintain weight and some medications needed to be taken with food.

Interview with the Dietary Manager (DM) on 04/23/25 at 5:10pm revealed:
-The kitchen did not send meals to the residents' rooms.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 338	Continued From page 197 -The residents had to have an order from the physician to have a meal delivered to their rooms. -She did not know what the residents that did not come to the dining room for meals ate for a meal. Interview with a personal care aide (PCA) on 04/22/25 at 12:05pm revealed: -There were a couple of residents who did not eat every day. -They would refuse to eat or would sleep through the meal. -One of the residents would come down about every three days or so and eat when he got hungry. Interview with a second PCA on 04/28/25 at 12:00pm revealed: -One of the residents only came to meals about once a week. -She would wave staff off and not want to eat so they left her alone. -She came to eat when she was ready to eat. -There was another resident who did not want to eat and would sleep through meals, but he had snacks in his room he could eat when he got hungry. -A third resident would not eat and would come down to eat every couple of days when he got hungry. -There was nothing they could do when a resident did not want to eat; they could refuse to eat. -The staff would ask the resident twice and then leave them alone. -She would report it to the medication aide (MA). Interview with a third PCA on 04/29/25 at 9:03am revealed: -She went around and told residents it was time to eat. -She would check on residents more than once	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 338	Continued From page 198	D 338		

and try to get them to eat.
-Some of the residents did not want to come down to eat so she left them alone.
-Sometimes the residents wanted to sleep.
-The residents usually did not skip more than one meal a day.
-The residents would eat a snack if they did not eat a meal.

Interview with a MA on 04/29/25 at 8:42am revealed:
-The PCAs went from room to room and told the residents it was time to eat.
-Sometimes she would stand in the hallway and announce it was time to eat.
-Some residents did not want to eat breakfast because they wanted to sleep in.
-Food trays were never delivered to the residents in their rooms.
-Sometimes the kitchen would fix extra plates that could be heated up but they were never delivered to the residents' rooms.

Interview with the Resident Care Coordinator (RCC) on 04/28/25 at 9:10am revealed:
-The PCAs were responsible for getting the residents to the dining room for meals.
-The PCAs were not assigned to halls, rooms, or residents; the PCAs worked together to get residents to meals.
-The PCAs went from room to room to tell the residents it was mealtime.
-If a resident refused to go to a meal the PCA told her or the Administrator.
-Residents did not eat in their rooms.
-The residents had the right to refuse to eat meals.

Interview with the Administrator on 04/29/25 at 4:35pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 338	Continued From page 199 -The staff were responsible for reminding the residents to come to meals. -The residents should be at all three meals. -The MAs announced over the public announcement system when it was mealtime; she had heard the announcement. -The PCAs and the MAs walked through the halls and looked in rooms for residents at meal times. -She told the staff to take trays to the residents in their rooms if the residents did not want to go to the dining room. -The staff could offer an alternative meal or a sandwich. -It was the residents' right to refuse meals, but they should not refuse more than one meal in a row. -She expected the staff to encourage the residents to go to the dining room to eat but they could not force the resident to eat. -If a resident refused to eat it should be documented; no one told her about residents missing meals. -She was concerned residents were missing meals because it could affect their weight and their nutrition. The facility failed to ensure the residents' rights were maintained by not contacting a resident's primary care provider to discuss the resident missing her medications while at an appointment and upon return to the facility she was in pain and having anxiety. Multiple residents did not have toilet paper in their bathrooms, which resulted in a resident using her hand to wipe herself; and residents who were not called to meals, missed the meal because no one told them it was time for the meal or checked to see why they did not go. The failure of the facility to ensure the residents' rights were maintained resulted in neglect of the residents and constitutes a Type A1	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 338	Continued From page 200 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on April 28, 2025 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MAY 29, 2025.	D 338		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to clarify orders with the prescribing physician for 1 of 5 sampled residents for a fingerstick blood sugar (FSBS) check and a blood pressure (BP) reading with a range to hold a BP medication (#3). The findings are: Review of Resident #3's current FL-2 dated	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 344	Continued From page 201 07/22/24 revealed diagnoses included diabetes mellitus, hypertension, and chronic kidney failure. a. Review of Resident #3's signed physician order dated 02/11/25 revealed: -There was an order for metoprolol 25mg (used to treat high BP) with metoprolol 100mg daily for a total of 125mg. -Hold metoprolol 25mg when Resident #3's BP readings was less than 140/90. Review of Resident #3's February 2025 electronic medication administration record (eMAR) from 02/11/25 to 02/28/25 revealed: -There was an order for metoprolol 25mg and metoprolol 100mg daily for a total of 125mg; hold metoprolol 25mg when Resident #3's BP reading was less than 140/90. -There was documentation that Resident #3's BP reading was recorded 7 of 10 times where the diastolic BP (DBP) was less than 90 from 02/18/25 to 02/27/25. Review of Resident #3's March 2025 eMAR revealed: -There was an order for metoprolol 25mg and metoprolol 100mg daily for a total of 125mg; hold metoprolol 25mg when Resident #3's BP reading was less than 140/90. -There was documentation that Resident #3's BP reading was recorded 19 of 24 times where the DBP was less than 90. Review of Resident #3's April 2025 eMAR from 04/01/25 to 04/22/25 revealed: -There was an order for metoprolol 25mg and metoprolol 100mg daily for a total of 125mg; hold metoprolol 25mg when Resident #3's BP reading was less than 140/90. -There was documentation that Resident #3's BP	D 344		

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D 344	Continued From page 202	D 344		

reading was recorded 14 of 19 times where the DBP was less than 90.

Telephone interview with Resident #3's Primary Care Provider (PCP) on 04/25/25 at 3:00pm revealed:
-She expected Resident #3's metoprolol 25mg to be held if the systolic BP (SBP) was less than 140 or the DBP was less than 90.
-If the medication aides (MA) were confused about the order, she would expect the MAs to ask for clarification.
-She expected metoprolol 25mg to be held if either, the SBP or DBP was below the ordered BP range.
-Resident #3 could experience a hypotensive episode if the metoprolol 25mg was not held as ordered.

Interview with a MA on 04/29/25 at 10:15am revealed:
-Resident #3's order was to hold metoprolol 25mg if the BP reading was less than 140/90.
-She was not sure if it meant both SBP and DBP readings had be lower or one of the two BP readings had to be lower in order to hold the medication.
-She had thought about whether both the SBP and the DBP had to be less than 140/90 or if only the SBP or the DBP had to be less than 140/90 but she had not asked anyone to clarify.
-The PCP should have been notified to clarify the order.

Interview with the RCC on 04/28/25 at 2:46pm revealed:
-The MAs should have clarified the order of when to hold metoprolol 25mg for a BP reading less than 140/90.
-It was not clear whether to hold metoprolol if the

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D 344	Continued From page 203 SBP and DBP readings were below 140/90 or if the SBP reading was below 140 or the DBP reading was below 90. -The PCP should have been notified to clarify the order. Interview with the Administrator on 04/29/25 at 4:53pm revealed the MAs should have clarified with the PCP to verify the BP range and when to hold the metoprolol 25mg. b. Review of Resident #3's signed physicians' orders dated 12/31/24 revealed: -There was an order for FSBS checks every 30 minutes as needed (PRN) for monitoring hypoglycemia or hyperglycemia. -There was an order to administer Lantus insulin (use to lower blood sugar) 20 units every morning; hold if FSBS reading was less than 85. -There was an order to administer Lantus insulin 9 units every evening; hold if FSBS reading was less than 85. -There was no order to check Resident #3's FSBS twice daily. Review of Resident #3's February 2025 eMAR from 02/11/25 to 02/28/25 revealed: -There was an order to check FSBS every 30 minutes PRN for monitoring hypoglycemia or hyperglycemia. -There was an entry to administer Lantus insulin 20 units every morning and hold if FSBS reading was less than 85; there was a place to document the FSBS reading. -There was an entry to administer Lantus insulin 9 units every evening and hold if FSBS reading was less than 85; there was a place to document the FSBS reading. -There was documentation FSBS readings were documented 26 out of 28 mornings from 02/01/25	D 344		

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D 344	Continued From page 204 to 02/28/25. -There was documentation FSBS readings were documented 21 of 28 evenings from 02/01/25 to 02/28/25. -There were no FSBS readings less than 85 in the morning or evening from 02/01/25 to 02/28/25. Review of Resident #3's March 2025 eMAR revealed: -There was an order to check FSBS every 30 minutes PRN for monitoring hypoglycemia or hyperglycemia. -There was an entry to administer Lantus insulin 20 units every morning and hold if FSBS reading was less than 85; there was a place to document the FSBS reading. -There was an entry to administer Lantus insulin 9 units every evening and hold if FSBS reading was less than 85; there was a place to document the FSBS reading. -There was documentation FSBS readings were documented 28 of 31 mornings from 03/01/25 to 03/31/25. -There was documentation FSBS readings were documented 26 of 31 evenings from 03/01/25 to 03/31/25. -There were no FSBS readings less than 85 in the morning or evening from 03/01/25 to 03/31/25. Review of Resident #3's April 2025 eMAR from 04/01/25 to 04/22/25 revealed: -There was an order to check FSBS every 30 minutes PRN for monitoring hypoglycemia or hyperglycemia. -There was an entry to administer Lantus insulin 20 units every morning and hold if FSBS reading was less than 85; there was a place to document the FSBS reading.	D 344		

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D 344	Continued From page 205	D 344		

-There was an entry to administer Lantus insulin 9 units every evening and hold if FSBS reading was less than 85; there was a place to document the FSBS reading.
-There was documentation FSBS readings were documented 21 of 22 mornings from 04/01/25 to 04/22/25.
-There was documentation FSBS readings were documented 18 of 21 evenings from 04/01/25 to 04/21/25.
-There were no FSBS readings less than 85 in the morning or evening from 04/01/25 to 04/22/25.

Interview with Resident #3 on 04/22/25 at 11:38am revealed:
-He was a diabetic and received insulin twice daily.
-His FSBS was checked twice daily by the staff.

Telephone interview with Resident #3's PCP on 04/25/25 at 3:00pm revealed:
-Resident #3 had an order for Lantus twice a day and to hold if his FSBS reading was less than 85.
-She did not know there was no order to check Resident #3's FSBS twice daily.
-The staff had not requested an order for FSBS readings twice daily.

Interview with the Special Care Coordinator (SCC) on 04/25/25 at 9:15am revealed:
-She did not see a scheduled order for FSBS checks twice daily.
-She only saw a PRN order for FSBS checks.
-The MAs should have noticed there was no order for FSBS checks and requested the order from the PCP.

Interview with the Administrator on 04/29/25 at 4:53pm revealed the MAs should have clarified if

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D 344	Continued From page 206 the FSBS checks were to be twice daily or PRN.	D 344		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 5 of 6 sampled residents (#1, #2, #3, #4, and #6) including a medication used to treat high blood pressure (#1); medications for anxiety, an antibiotic, a pain reliever, insulin, a laxative, a pain patch, and a sedative (#2); a nebulizer treatment, an inhaler, a medication to remove fluid, and a blood pressure medication (#3); an antipsychotic medication, an antianxiety medication, and a sleep aid (#4); and two pain medications (#6). The findings are: 1. Review of Resident #2's current FL-2 dated 01/28/25 revealed diagnoses included dysphagia, chronic pain, hyperlipidemia, anxiety, muscle weakness, edema, and chronic obstructive pulmonary disease (COPD).	D 358		

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D 358	Continued From page 207 a. Review of Resident #2's current FL-2 dated 01/28/25 revealed there was an order for lorazepam (used to treat anxiety) 1mg three times daily. Review of Resident #2's signed physician's order dated 04/01/25 revealed there was an order for lorazepam 1mg three times daily. Review of Resident #2's electronic medication administration record (eMAR) for February 2025 revealed: -There was an entry for lorazepam 1mg three times daily scheduled at 8:00am, 2:00pm, and 8:00pm. -There was documentation Resident #2 was at the hospital on 02/03/25 and from 02/18/25 to 02/28/25. -There was no documentation lorazepam was administered on 02/05/25 at 8:00am, 02/14/25 at 2:00pm, on 02/16/25 at 2:00pm and 8:00pm, and on 02/17/25 at 8:00am, 2:00pm and 8:00pm. -There was documentation on 02/07/25 at 8:00am Resident #2 was physically unable to take medication because she was asleep. -Resident #2 was not administered lorazepam 8 out of 48 opportunities from 02/01/25 to 02/18/25. Review of Resident #2's lorazepam 1mg control substance count sheet (CSCS) for February 2025 revealed Resident #2 was administered 41 tablets of lorazepam from 02/01/25 to 02/16/25. Review of Resident #2's eMAR for March 2025 revealed: -There was an entry for lorazepam 1mg three times daily scheduled at 8:00am, 2:00pm, and 8:00pm. -There was documentation Resident #2 was at the hospital from 03/01/25 to 03/03/25.	D 358		

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D 358	Continued From page 208 -There was documentation Resident #2 was out of the facility on 03/07/25 at 11:16am, 03/21/25 at 7:12pm and 03/24/25 at 4:51pm. -There was documentation Resident #2 refused lorazepam on 03/09/25 at 2:00pm, and 03/24/25 at 1:37pm. -There was documentation Resident #2's lorazepam was on order from the pharmacy on 03/18/25 at 8:23pm and on 03/19/25 at 8:04pm. -There was no documentation lorazepam was administered on 03/08/25, 03/23/25 and 03/29/25 at 8:00am. -Resident #2 was not administered her lorazepam 8 out of 84 opportunities from 03/04/25 to 03/31/25. Review of Resident #2's lorazepam 1mg CSCS for March 2025 revealed Resident #2 was administered 73 tablets of lorazepam 1 mg from 03/03/25 to 03/31/25. Review of Resident #2's eMAR for April 2025 from 04/01/25 to 04/22/25 revealed: -There was an entry for lorazepam 1mg three times daily scheduled at 8:00am, 2:00pm, and 8:00pm. -There was documentation Resident #2 was at the hospital on 04/14/25. -There was no documentation lorazepam was administered on 04/02/25 at 2:00pm and 04/04/25 at 8:00am. -There was documentation lorazepam was not administered 2 of 62 opportunities. Review of Resident #2's lorazepam 1mg CSCS for April 2025 revealed: -There was a CSCS from 04/01/25 to 04/14/25. -There was documentation Resident #2 was administered 39 tablets of lorazepam from 04/01/25 to 04/14/25.	D 358		

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D 358	Continued From page 209 -There was a second CSCS dated from 04/16/25 to 04/22/25. -There was documentation Resident #2 was administered 15 tablets of lorazepam from 04/16/25 to 04/22/25. -There was nothing documented as administered on either April 2025 CSCS for 04/15/25. Observation of Resident #2's medication on hand on 04/23/25 at 11:55am revealed: -There was a medication card of 30 tablets of lorazepam 1mg dispensed on 04/15/2025. -There were 15 tablets available for administration in the medication card. Telephone interview with a pharmacist from the facility's contracted pharmacy on 04/28/25 at 3:30pm revealed: -Resident #2 had a current order for lorazepam 1mg scheduled three times daily. -Ninety tablets of lorazepam were dispensed on 01/23/25. -Ninety tablets of lorazepam were dispensed on 02/08/25. -Thirty tablets were dispensed on 04/15/25. -Lorazepam was used to treat anxiety; if doses were missed the resident could experience anxiety or agitation, be more alert and possibly more unruly. -Lorazepam was not on a cycle fill and required an order for refill. Telephone interview with the facility's contracted mental health provider (MHP) on 02/25/25 at 4:55pm revealed: -Resident #2 was ordered lorazepam for anxiety and agitation. -Lorazepam needed to be used cautiously when ordered for the elderly because it could cause confusion.	D 358		

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D 358	Continued From page 210 -The goal was to reduce Resident #2's lorazepam but she was not stable yet and still had a lot of anxiety. -She would reduce the lorazepam once her agitation was under control, but it would have to be stepped down and tapered off. -Missed doses of lorazepam would cause increased agitation. -If she missed more than two to three days of doses, she could go through withdrawal. -The facility staff should follow the orders for the lorazepam at all times. Interview with Resident #2 on 04/23/25 at 10:50am revealed: -She had an order for lorazepam three times a day for anxiety. -She did not always get her lorazepam because she kept up with her medications and she knew what was missing. -Sometimes they just did not give her all her medications and would tell her "it is in there [medication cup]". -They had run out of her lorazepam just last week. -The medication aide (MA) told her they did not have the lorazepam because they were waiting on the Veterans Administration (VA) or the PCP to send the order to the facility's pharmacy. -Lorazepam was the most important medication she took because it was for her anxiety. Interview with an MA on 04/25/25 at 11:35am revealed: -Resident #2 knew her medication and counted her tablets while they were in the medication cup. -There were blanks on the eMAR for some of the medications because if she did not have a medication, she just left it blank or documented "waiting on pharmacy".	D 358		

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D 358	Continued From page 211 -Medications were reordered when they were in the blue area on the medication cards. -Medications were reordered through the eMAR system by clicking on reorder. -She documented controlled medications on the eMAR and the CSCS when she administered them. -If she had documented on the eMAR that she administered a medication then she had administered it. Interview with the Resident Care Coordinator (RCC) on 04/29/25 at 11:45am revealed: -The MAs documented on the eMAR and then on the CSCS when they administered lorazepam. -If the lorazepam CSCS count matched the lorazepam tablet count but the eMAR had documented administrations that were not documented on the CSCS then the MAs were not administering the lorazepam, but documenting it on the eMAR as done. -The MAs were in a rush and clicking off on the eMAR before they popped a tablet out of a card. -The MAs were not checking the medication against the eMAR and were documenting medications they did not administer as administered. -Her concern for Resident #2 was she would get anxious and scream, cry, and have noises in her ear because her lorazepam helped her with all of those. -Medication administration was the facility's responsibility, not the residents. Interview with the Administrator on 04/29/25 at 4:35pm revealed if Resident #2 did not receive her lorazepam as ordered the facility was the cause of some of her anxiety. b. Review of Resident #2's signed physicians	D 358		

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D 358	Continued From page 212 order dated 02/13/25 revealed there was an order for doxycycline (an antibiotic) 100mg twice daily for seven days. Review of Resident #2's eMAR for February 2025 revealed: -There was an entry for doxycycline 100mg twice daily scheduled at 8:00am and 8:00pm. -There was a note under the entry Resident #2 was out of the facility from 02/18/25 to 03/03/25. -Resident #2's doxycycline was not documented as administered and there were no exceptions documented from 02/13/25 to 02/18/25. Observation of Resident #2's medication on hand on 04/23/25 at 11:55am revealed there was no doxycycline available for administration. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 04/23/25 at 4:15pm revealed: -Resident #2 had an electronic order dated 02/13/25 for doxycycline 100mg twice daily for seven days. -Fourteen tablets of doxycycline were dispensed on 02/13/25. -The pharmacy entered the orders for medications into the eMARs. Telephone interview with the pharmacist from the facility's contracted pharmacy on 04/28/25 at 3:30pm revealed: -Doxycycline was an antibiotic typically ordered for respiratory infections; it was used to treat pneumonia and skin infections. -If doxycycline was not administered as ordered the infection would not be treated and the resident could take longer to heal, or the infection could spread or worsen.	D 358		

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(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) COMPLETE DATE
D 358	Continued From page 213 Interview with Resident #2's PCP on 04/29/25 at 12:00pm revealed: -She was not sure why Resident #2 was ordered they doxycycline. -The doxycycline was ordered by the triage team [on call physician] and she did not see a note in the resident's record why it was ordered. -Doxycycline was typically ordered for pneumonia or a skin rash. -She thought Resident #2 had some history of pneumonia and respiratory infections; Resident #2 had COPD. -She should have been administered the doxycycline twice daily for seven days as ordered because she could have ended up in the hospital. Interview with Resident #2 on 04/25/25 at 10:14am revealed: -She had been sick with breathing problems in February 2025. -It was respiratory, but she did not think it was pneumonia; it was in her chest and she was coughing. -She did not remember an order for an antibiotic, and she did not recall if she took an antibiotic in February 2025. Interview with a MA on 04/25/25 at 11:35am revealed: -Resident #2 knew her medication and counted her tablets while they were in the medication cup. -There were blanks on the eMAR for some of the medications because if she did not have a medication, she just left it blank or documented "waiting on pharmacy". -She could not remember if doxycycline was ordered for Resident #2 in February 2025, but it did not mean the resident did not receive doxycycline. -If there was a medication on the eMAR when	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 358	Continued From page 214	D 358		

she was administering medications then she administered it.
-If she was administering medications on one of days Resident #2 was scheduled to get it then, she must have just missed documenting on the eMAR.

Telephone interview with a MA on 04/28/25 at 7:17pm revealed:
-Resident #2 tried to keep up with her medications and would tell you what most of her medications were.
-Resident #2 would notice a new tablet if it were administered to her and ask about it.
-She could not recall if Resident #2 was ordered doxycycline around 02/13/25.
-She always documented everything she administered on the eMAR or wrote a reason like refusal if the resident was not administered something.

Interview with the RCC on 04/29/25 at 5:40pm revealed:
-She did not work at the facility in February 2025 so she could not say what happened concerning Resident #2's doxycycline.
-If there was an entry on the eMAR then the MAs should have administered it.
-If there was no documentation of administration on the eMAR then it did not happen.

Interview with the Administrator on 04/29/25 at 4:35pm revealed she could not speak about medication administration and documentation that happened in February 2025 because she did not work at the facility at that time.

c. Review of Resident #2's current FL-2 dated 01/28/25 revealed there was an order for gabapentin (used to treat pain) 800mg three

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 358	Continued From page 215 times daily. Review of Resident #2's hospital discharge notes dated 03/03/25 revealed: -She was admitted to the hospital on 02/18/25 due to a fall. -There was an order for gabapentin 300mg take two tablets three times daily. -The physician noted the reason for the reduction or change in the dosage of some of her medications was because after reviewing them it was determined some of them could cause confusion and increased risk of falls. Review of Resident #2's signed physician order from the Veterans Administration (VA) dated 03/02/25 revealed: -There was an order for gabapentin 300mg take two tablets three times daily. -The order was signed by the facility's primary care provider (PCP) on 03/11/25. Review of a signed physician's order dated 04/01/25 revealed there was an order for gabapentin 800mg take one tablet three times daily. Review of Resident #2's electronic medication administration record (eMAR) for March 2025 revealed: -There was an entry for gabapentin 800mg three times daily scheduled at 8:00am, 2:00pm and 8:00pm. -There was documentation Resident #2 was administered gabapentin 800mg three times daily 73 of 84 opportunities from 03/04/25 to 03/31/25. -There was no entry for gabapentin 300mg take two tablets three times daily. Review of Resident #2's eMAR for April 2025	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 358	Continued From page 216 from 04/01/25 to 04/22/25 revealed: -There was an entry for gabapentin 800mg three times daily scheduled at 8:00am, 2:00pm and 8:00pm. -Gabapentin was documented as administered 62 of 65 opportunities. -There was no entry for gabapentin 300mg take two tablets three times daily. Observation of Resident #2's medication on hand on 04/23/25 at 11:55am revealed: -There was a card with 30 of ninety tablets of gabapentin 800mg take one tablet three times daily dispensed on 04/15/25: there were 23 tablets of gabapentin 800mg available for administration in the card. -There was a second medication card with 30 of 90 tablets of gabapentin 800mg take one tablet three times daily dispensed on 04/15/25: there were 30 tablets of gabapentin 800mg available for administration in the card. -There was a third medication card with 30 of 90 tablets of gabapentin 800mg take one tablet three times daily dispensed in on 04/15/25: there were 30 tablets of gabapentin 800mg available for administration in the card. Observation of Resident #2's medication on hand on 04/24/25 at 5:27pm revealed: -Resident #2 had medication that was stored in a large paper bag with other medications and kept in a locked closet in the office the Administrator and the Resident Care Coordinator (RCC) shared. -There was a medication bottle with 90 of 180 tablets of gabapentin 300mg take two tablets three times daily dispensed on 03/03/25; there were 90 tablets available for administration. -There was a second medication bottle with 90 of 180 tablets of gabapentin 300mg take two tablets	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 358	Continued From page 217 three times daily dispensed on 03/03/25; there were 90 tablets available for administration. Telephone interview with the pharmacist from the facility's contracted pharmacy on 04/28/25 at 3:30pm revealed: -Resident #2 had a current order for gabapentin 800mg three times daily. -The pharmacy had never received an order for Resident #2 for gabapentin 300mg take two tablets three times daily. -Ninety tablets of gabapentin 800mg had been dispensed on 01/23/25, 03/19/25 and 04/15/25. -Gabapentin 800mg was not on cycle fill and needed to be requested by the facility for refill. -If a medication order was signed and dated by a physician it was considered a valid and active order; the pharmacy could fill the order once they received it. -Gabapentin was used to treat nerve pain and neuropathy. -If a higher milligram was administered than ordered the resident could experience sedation, increased drowsiness, confusion, and dizziness. Telephone interview with a Registered Nurse from the VA on 04/29/25 at 9:40am revealed: -Resident #2 was discharged from the VA hospital with new medications because of a concern for polypharmacy. -Resident #2's gabapentin was decreased to 600mg three times daily on 03/03/25, to address the polypharmacy. Interview with Resident #2's primary care provider (PCP) on 04/29/25 at 12:00pm revealed: -She had agreed to the change for Resident #2's gabapentin to 600mg three times daily. -She signed the orders from the VA hospital so the facility could put them in the eMAR and begin	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 358	Continued From page 218	D 358		

to administer them.
-The facility did not reach out to her about using the gabapentin that was dispensed from the VA pharmacy.
-They could have administered the gabapentin dispensed from the VA pharmacy to Resident #2.

Interview with Resident #2 on 04/25/25 at 10:05am revealed:
-The VA hospital gave her all her medications before she left the hospital.
-They also gave her a stack of orders and discharge paperwork.
-She gave all the paperwork from the hospital to the Administrator when she returned on 03/03/25.
-The Administrator told her to give her the paperwork so it could be put into the "system".
-The RCC took the bag of medications the VA had dispensed to her and put them in the closet in her office.
-She was told by the Administrator that she had to use the facility's pharmacy because it would cause too much confusion to use the VA's pharmacy.
-She was administered one gabapentin tablet three times a day for her muscle pain.
-She was "pretty sure" she was administered 800mg of gabapentin; she knew the tablet was white.

Telephone interview with a medication aide (MA) on 04/28/25 at 7:17pm revealed:
-Resident #2 tried to keep up with her medications and would tell you what most of her medications were.
-She thought Resident #2 had some medications she got three times a day, but she did not recall what they were.
-MAs were responsible for scanning or faxing new medication orders to the pharmacy if the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 358	Continued From page 219	D 358		

PCP did not send them.
-She did not know who was responsible for entering the medication orders into the eMAR.

Interview with the RCC on 04/24/25 at 3:50pm revealed:
-Resident #2 was in the hospital when she started working at the facility, so she did not know why she was admitted to the hospital in February 2025.
-She returned to the facility from the VA hospital with a large paper bag with medications on 03/03/25.
-The facility did not have orders for the medications, there was only literature that came with the medications they dispensed.
-She was waiting for the facility's PCP to get the medication orders from the VA.
-She placed the bag with Resident #2's medication from the VA in the closet in her office until she received orders.
-She was going to return the medication to the VA pharmacy today, 04/24/25 because she did not have signed orders from the VA or the facility's PCP.
-She had not called the VA to attempt to get orders for the medications.
-She noticed the bottle of gabapentin from the VA pharmacy was only 300mg per tablet and Resident #2 had an order for 800mg three times daily.
-The gabapentin tablets that were 300mg could not be administered because there was no way to get 800mg from the 300mg tablets.

Interview with the Administrator on 04/29/25 at 4:35pm revealed because they were not following the dose reduction ordered for Resident #2's gabapentin; she was concerned she was receiving too much medication, and the PCP

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 358	Continued From page 220 reduced it for a reason. Attempted telephone interview with the pharmacist from the VA pharmacy on 10:35am was unsuccessful. d. Review of Resident #2's current FL-2 dated 01/28/25 revealed an order for insulin aspart (used to lower blood glucose levels) 100units/mL inject 15 units three times daily. Review of Resident #2's PCP after visit notes dated 02/11/25 revealed Resident #2 had an order for insulin aspart 100unit/mL inject 15 units three times daily before meals. Review of Resident #2's signed physician's orders dated 04/01/25 revealed an order for insulin aspart 100unit/mL inject 15 units three times daily before meals. Review of Resident #2's electronic medication administration record (eMAR) for February 2025 revealed: -There was an entry for insulin aspart 100/ml inject 15 units three times daily scheduled at 7:00am, 11:00am and 5:00pm. -Resident #2 was documented as out to the hospital from 02/18/25 to 02/28/25. -Resident #2's insulin aspart was not documented as administered 8 times from 02/01/25 to 02/17/25; there were blanks on the eMAR. -Resident #2's insulin aspart was not administered 8 of 51 opportunities from 02/01/25 to 02/17/25. Review of Resident #2's eMAR for March 2025 revealed: -There was an entry for insulin aspart 100/ml inject 15 units three times daily scheduled at	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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) COMPLETE DATE
D 358	Continued From page 221	D 358		

7:00am, 11:00am and 5:00pm.
-There was documentation Resident #2 was at the hospital from 03/01/25 to 03/03/25.
-Resident #2's insulin aspart was not documented as administered 6 opportunities from 03/03/25 to 03/31/25; there were blanks on the eMAR.
-Resident #2's insulin aspart was not administered 6 of 84 opportunities from 03/03/25 to 03/31/25.

Review of Resident #2's eMAR for April 2025 from 04/01/25 to 04/22/25 revealed:
-There was an entry for insulin aspart 100/ml inject 15 units three times daily scheduled at 7:00am, 11:00am and 5:00pm.
-There was documentation Resident #2 was in the hospital on 04/14/25 and out of the facility on 04/17/25 at 11:00am.
-Resident #2's insulin aspart was not documented as administered 8 opportunities; there were blanks in the eMAR.
-Resident #2's insulin aspart was not administered 11 of 60 opportunities

Observation of Resident #2's medication on hand on 04/23/25 at 11:55am revealed:
-There was a 10mL multi dose vial of insulin dispensed on 04/10/25.
-There was an open date of 04/20/25 on the vial.
-There was approximately half of the vial available for administration.

Telephone interview with the pharmacist from the facility's contracted pharmacy on 04/28/25 at 3:30pm revealed:
-Resident #2 had a current order for insulin aspart inject 15 units three times daily before meals.
-Resident #2 was dispensed a 22-day supply of insulin aspart in a multidose vial on 01/23/25, 03/04/25 and 04/10/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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) COMPLETE DATE
D 358	Continued From page 222 -Resident #2's insulin aspart was not on a cycle fill and the facility had to request a refill needed. -Insulin aspart was a short acting insulin used to lower blood sugar levels for residents with higher blood sugar levels that tended to fluctuate and go up and down. -If a resident missed a dose of insulin aspart their blood sugar levels could go up especially when eating sugary foods. Interview with Resident #2's primary care provider (PCP) on 04/29/25 at 12:00pm revealed: -Resident #2 had an order for insulin aspart because she was hyperglycemic and had diabetes. -Resident #2 needed the short acting insulin before she ate to keep her blood sugar levels from going above 200. -Resident #2 should have been administered the insulin aspart three times daily as ordered unless she gave verbal orders to hold due to Finger Stick Blood Sugar (FSBS) results. Interview with Resident #2 on 04/25/25 at 10:30am revealed: -She was diagnosed diabetic before she was admitted to the facility. -She was administered insulin three times a day. -She did not always take her insulin because sometimes her finger stick blood sugar (FSBS) results were low and she knew not to take her insulin. -Sometimes she would remind the medication aide (MA) she needed to get her insulin. -She was not going to let them forget her insulin injections. Interview with a medication aide (MA) on 04/23/25 at 2:55pm revealed: -Resident #2 had insulin injections three times a	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 358	Continued From page 223	D 358		

day before her meals.
-The insulin was in a vial and not a preloaded pen.
-She always documented the insulin administration; sometimes she had to hold it per the PCP's order or when the resident told her she did not want it because her FSBS results were low, then it was a refusal.

Interview with the Resident Care Coordinator (RCC) on 04/29/25 at 11:30am:
-If Resident #2's insulin aspart was not documented as administered then it was not given.
-Her concern was that if she did not receive her insulin her FSBS result could elevate.
-She expected the MAs to follow the entries in the eMAR and to document the administrations and the refusals as they had been trained.

Interview with the Administrator 04/29/25 at 4:35pm revealed if a medication was not documented as administered, then it was not administered.

e. Review of Resident #2's discharge notes from the Veteran's Administration (VA) hospital dated 03/03/25 revealed:
-She was admitted to the hospital on 02/18/25 due to a fall.
-She was diagnosed with an ileus (slowing of the intestine) while in the hospital.
-There was an order for polyethylene glycol (used to treat constipation) mix 17gm in liquid once daily.

Review Resident #2's physician's order from the VA dated 03/02/25 revealed:
-There was an order for polyethylene glycol mix 17gm in liquid once daily.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 358	Continued From page 224 -The order was signed by the facility's primary care provider (PCP) on 03/11/25. Review of Resident #2's electronic medication administration records (eMARs) for March 2025 and April 2025 from 04/01/25 to 04/22/25 revealed there was no entry for polyethylene glycol mix 17gm into liquid once daily. Observation of Resident #2's medication on hand on 04/23/25 at 11:55am revealed there was no polyethylene glycol for Resident #2 on the medication cart or in the medication room. Observation of Resident #2's medication on hand on 04/24/25 at 5:27pm revealed: -Resident #2 had medication that was stored in a large paper bag with other medications and kept in a locked closet in the office the Administrator and the Resident Care Coordinator (RCC) shared. -There was an unopened bottle of polyethylene glycol with a pharmacy label but no dispense date on the label. Telephone interview with the pharmacist from the facility's contracted pharmacy on 04/28/25 at 3:30pm revealed: -Resident #2 did not have an order for polyethylene glycol 17mg once daily. -The pharmacy had never received an order for Resident #2 for polyethylene glycol. -If a medication order was signed and dated by a physician it was considered a valid and active order; the pharmacy could fill the order once they received it. Telephone interview with the Registered Nurse from the VA on 04/25/25 at 2:32pm revealed Resident #2 had an order for polyethylene glycol	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 358	Continued From page 225 for constipation because she had an ileus while in the hospital in March 2025. Interview with Resident #2's PCP on 04/29/25 at 12:00pm revealed: -She had agreed to the order for Resident #2's polyethylene glycol 17mg once daily. -She signed the orders from the VA hospital so the facility could put them in the eMAR and begin to administer the medication. -The facility did not reach out to her about using the polyethylene glycol that was dispensed from the VA pharmacy. -They could have administered the polyethylene glycol dispensed from the VA pharmacy to Resident #2. Interview with Resident #2 on 04/25/25 at 10:05am revealed: -The VA hospital gave her all her medications before she left the hospital. -They also gave her a stack of orders and discharge paperwork. -She gave all the paperwork from the hospital to the Administrator when she returned on 03/03/25. -The Administrator told her to give her the paperwork so it could be put into the "system". -The RCC took the bag of medications the VA had dispensed to her and put them in the closet in her office. -She was told by the Administrator that she had to use the facility's pharmacy because it would cause too much confusion and chaos to use the VA's pharmacy. -She had gone to the hospital because she was "backed up" and had not had a bowel movement for at least a week. -She had a bottle of polyethylene glycol in the bag from the VA, but the facility would not let her have it.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 358	Continued From page 226 -She had not had any issues with constipation since her return from the hospital. Telephone interview with a medication aide (MA) on 04/28/25 at 7:17pm revealed: -Resident #2 did not have a scheduled order for polyethylene glycol. -Resident #2 had an order for a laxative that was as needed (PRN). -Resident #2 had not complained about constipation to her. Interview with the RCC on 04/24/25 at 4:45pm revealed: -All documents including medication orders, discharge records and after visit reports were placed into a book for the facility's PCP to review and sign and then they were placed into the resident's medical records. -Resident #2 returned from a stay at the VA hospital in March 2025. -When she returned to the facility, she brought medications that were dispensed from the VA hospital. -The facility wanted the facility's PCP to review the medications before administering them because they did not have orders for the medications. -Resident #2's medications were already in a large paper bag, so she placed them in a closet in her office. -She was going to send the medications back to the VA pharmacy because Resident #2 received her medications from the facility's contracted pharmacy. Interview with the Administrator on 04/29/25 at 4:35pm revealed Resident #2's polyethylene glycol should have been administered to her as ordered once the PCP signed the orders.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 358	Continued From page 227 Attempted telephone interview with the pharmacist from the VA pharmacy on 10:35am was unsuccessful. f. Review of Resident #2's discharge notes from the Veteran's Administration (VA) hospital dated 03/03/25 revealed: -She was admitted to the hospital on 02/18/25 due to a fall. -There was an order for lidocaine patch (used to relieve pain) 5% apply for 12 hours and remove for 12 hours daily. Review Resident #2's physician order from the VA dated 03/02/25 revealed: -There was an order for lidocaine patch 5% apply for 12 hours and remove for 12 hours daily. -The order was signed by the facility's primary care provider (PCP) on 03/11/25. Review of Resident #2's electronic medication administration records (eMARs) for March 2025 and April 2025 revealed there was no entry for lidocaine patch 5% apply for 12 hours and remove for 12 hours daily. Observation of Resident #2's medication on hand on 04/23/25 at 11:55am revealed there were no lidocaine patches for Resident #2 on the medication cart or in the medication room. Telephone interview with the pharmacist from the facility's contracted pharmacy on 04/28/25 at 3:30pm revealed: -The pharmacy had never received an order for Resident #2 for a lidocaine patch 5% apply 12 hours and remove 12 hours daily. -Lidocaine patches were a topical nerve pain blocker when they were applied directly to the	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 358	Continued From page 228	D 358		

area where the pain was; if not applied there would not be relief from pain in the area.
-If a medication order was signed and dated by a physician it was considered a valid and active order; the pharmacy could fill the order once they received it.

Interview with Resident #2 on 04/25/25 at 10:05am revealed:
-The VA hospital gave her a stack of orders and discharge paperwork after her hospital stay.
-She gave all the paperwork from the hospital to the Administrator when she returned on 03/03/25.
-The Administrator told her to give her the paperwork so it could be put into the "system".
-She had pain in her knees all the time and she thought the lidocaine patches might have been ordered for her knees.
-She had used them in the past and they had worked to relieve her pain.
-She did not ask about the lidocaine patches because she did not realize she had an order for them.

Interview with Resident #2's PCP on 04/29/25 at 12:00pm revealed:
-She had agreed to the order for Resident #2's lidocaine patch 5% apply for 12 hours remove for 12 hours.
-She signed the orders from the VA hospital so the facility could put them in the eMAR and begin to administer the medication.

Telephone interview with a medication aide (MA) on 04/28/25 at 7:17pm revealed:
-She had never seen a lidocaine patch for Resident #2.
-She had never applied or removed a lidocaine patch for Resident #2.
-She thought Resident #2 did not have a lidocaine

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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) COMPLETE DATE
D 358	Continued From page 229	D 358		

patch ordered because she had a cream she put on her knees for pain.
-If Resident #2 had an order for lidocaine patches, she would ask for them.

Interview with the Administrator on 04/29/25 at 4:35pm revealed Resident #2's order for lidocaine patches should have implemented and applied and removed daily as ordered by the PCP.

Attempted telephone interview with the pharmacist from the VA pharmacy on 10:35am was unsuccessful.

g. Review of Resident #2's discharge notes from the Veteran's Administration (VA) hospital dated 03/03/25 revealed there was an order for trazodone (used to treat insomnia associated with depression) 100mg take one and a half tablets at bedtime.

Review Resident #2's physician order from the VA dated 03/02/25 revealed:
-There was an order for trazodone 100mg take one and a half tables at bedtime.
-The order was signed by the facility's primary care provider (PCP) on 03/11/25.

Review of Resident #2's electronic medication administration record (eMAR) for March 2025 and April 2025 from 04/01/25 to 04/22/25 revealed there was no entry for trazodone 100mg take one and a half tables at bedtime.

Observation of Resident #2's medication on hand on 04/23/25 at 11:55am revealed there was no trazodone for Resident #2 on the medication cart or in the medication room.

Observation of Resident #2's medication on hand

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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) COMPLETE DATE
D 358	Continued From page 230 on 04/24/25 at 5:27pm revealed: -Resident #2 had medication that was dispensed by the VA and was stored in a large paper bag with other medications and kept in a locked closet in the office the Administrator and the Resident Care Coordinator (RCC) shared. -There was a medication bottle with 45 tablets of trazodone 100mg take one and a half tablets at bedtime for insomnia associated with depression dispensed on 03/03/25; there were 45 tablets available for administration. Telephone interview with the pharmacist from the facility's contracted pharmacy on 04/28/25 at 3:30pm revealed: -The pharmacy had never received an order for Resident #2 for trazodone 100mg take one and a half tablets at bedtime. -Trazodone was an antidepressant that was sedating and would aid with sleep and the reason it was ordered for administration at bedtime; if not administered the resident could have difficulty falling asleep and have some irritation at bedtime. -If a medication order was signed and dated by a physician it was considered a valid and active order; the pharmacy could fill the order once they received it. Telephone interview with the Registered Nurse from the VA on 04/29/25 at 9:40am revealed trazodone was ordered to help her sleep at night because the goal was to decrease some of her other medications. Interview with Resident #2's PCP on 04/29/25 at 12:00pm revealed: -She had agreed to the order for Resident #2's trazodone 150mg at bedtime. -She signed the orders from the VA hospital so the facility could put them in the eMAR and begin	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 358	Continued From page 231	D 358		

to administer the medication.
-The facility did not reach out to her about using the trazodone that was dispensed from the VA pharmacy.
-They could have implemented the order and administered the trazodone dispensed from the VA pharmacy to Resident #2.

Interview with Resident #2 on 04/25/25 at 10:30am revealed:
-The VA hospital gave her a stack of orders and discharge paperwork after her hospital stay.
-She gave all the paperwork from the hospital to the Administrator when she returned on 03/03/25.
-The Administrator told her to give her the paperwork so it could be put into the "system".
-She did not have an order for trazodone that she knew of and had not been administered trazodone in the evenings.
-She had difficulty staying asleep at night.
-She would wake up with anxiety or pain and not be able to fall back to sleep.

Interview with Resident #2 on 04/29/25 at 8:05am revealed:
-She had anxiety and pain the night before, 04/28/25 and did not sleep.
-She was not herself and felt "off" that morning, 04/29/25, because she did not sleep the night before.

Telephone interview with a medication aide (MA) on 04/28/25 at 7:17pm revealed:
-She did not know if Resident #2 had an order for trazodone in the evening.
-Resident #2 did not have a problem sleeping; she usually wanted to sleep late in the mornings.

Interview with the Administrator on 04/29/25 at 4:35pm revealed Resident #2 should have been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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) COMPLETE DATE
D 358	Continued From page 232	D 358		

administered the trazodone after the PCP signed the order.

Attempted telephone interview with the pharmacist from the VA pharmacy on 10:35am was unsuccessful.

h. Review of Resident #2's discharge notes from the Veteran's Affairs (VA) hospital dated 03/03/25 revealed there was an order for lorazepam (used to treat anxiety) 0.5mg take one-half tablet daily as needed (PRN) for anxiety.

Observation of Resident #2 on 02/28/25 at 5:30pm revealed:
-Resident #2 was in the main lobby of the facility.
-She returned to the facility and complained of pain after a medical procedure.
-She became very upset and asked for medication for her pain and for her anxiety.
-Resident #2 was told she did not have a PRN medication for her anxiety and could not take anything for her anxiety until an hour before her scheduled medication time of 8:00pm.
-She told the medication aide (MA) she had not had her scheduled 2:00pm lorazepam because she was out of the facility and asked if she could be administered the medication now.
-She was told she did not have a PRN medication for her anxiety and could not take anything for her anxiety until an hour before her scheduled medication time of 8:00pm.
-Resident #2 began to raise her voice, cried out for help and begged for something to relieve her anxiety and pain.
-She requested the staff to call 911 to send her out or to contact her primary care provider (PCP).
-She was administered a PRN medication for her pain but was told there were no PRNs for her anxiety.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 233 Review of Resident #2's electronic medication administration record (eMAR) for March 2025 and April 2025 from 04/01/25 to 04/22/25 revealed there was no entry for lorazepam 0.5mg take one-half tablet daily PRN for anxiety. Observation of Resident #2's medication on hand on 04/23/25 at 11:55am revealed there was no lorazepam for Resident #2 on the medication cart or in the medication room. Observation of Resident #2's medication on hand on 04/24/25 at 5:27pm revealed: -Resident #2 had medication that was stored in a large paper bag with other medications and kept in a locked closet in the office the Administrator and the Resident Care Coordinator (RCC) shared. -The medications were dispensed from the VA pharmacy. -There was a medication bottle with 15 tablets of lorazepam 0.5mg take one-half tablet daily PRN for anxiety dispensed on 03/03/25; there were 15 tablets available for administration. Telephone interview with the pharmacist from the facility's contracted pharmacy on 04/28/25 at 3:30pm revealed: -The pharmacy had never received an order for Resident #2 for lorazepam 0.5mg take one-half tablet daily PRN for anxiety. -Lorazepam was used to treat anxiety; if not administered the resident could experience increased anxiety or agitation, be more alert and possibly more unruly. Interview with Resident #2 on 04/25/25 at 10:30am revealed: -The VA hospital gave her a stack of orders and	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 358	Continued From page 234	D 358		

discharge paperwork after her hospital stay.
-She gave all the paperwork from the hospital to the Administrator when she returned on 03/03/25.
-The Administrator told her to give her the paperwork so it could be put into the "system".
-She did not have an order for lorazepam PRN; she only had an order for scheduled lorazepam.
-Lorazepam was the most important medication because it helped her with her anxiety.

Interview with Resident #2 on 04/28/25 at 5:40pm revealed:
-She was experiencing pain, and she had anxiety because she was out of the facility for a medical procedure and had missed her scheduled dose of anxiety medication.
-Her anxiety was so elevated due to her pain she had tinnitus (buzzing or ringing sounds in the ears) so loud she could not think.
-It sounded and sounded like a "freight train" was in her ears and going through her.
-The MA refused to give her anything for her anxiety.

Interview with Resident #2 on 04/29/25 at 8:05am revealed:
-She did not sleep the night before, 04/28/25 because of anxiety from the pain from her procedure earlier in the day.
-She was given her scheduled dose of lorazepam, but she had so much anxiety it took her a while to feel calm.
-She did not feel herself and she felt "off" today, 04/29/25 because she did not sleep.
-She did not have a PRN order for her lorazepam.

Telephone interview with the Registered Nurse from the VA on 04/29/25 at 9:40am revealed lorazepam 0.5mg PRN was ordered for Resident #2 to help with anxiety for a short course.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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(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) COMPLETE DATE
D 358	Continued From page 235 Interview with Resident #2's PCP on 04/29/25 at 12:00pm revealed: -She had agreed to the order for Resident #2's lorazepam 0.5mg once daily PRN for agitation. -She signed the orders from the VA hospital so the facility could put them in the eMAR and begin to administer the medication. -The facility did not reach out to her about using the lorazepam that was dispensed from the VA pharmacy. -They could have implemented the PRN order for the lorazepam and administered IT for her anxiety the night before, 04/28/25. -The facility could have administered the lorazepam dispensed from the VA pharmacy. Interview with a MA on 04/28/25 at 5:45pm revealed Resident #2 did not have an order for lorazepam PRN, and she could not administer her anything to help with her anxiety; "this is the way she does when she wants something". Telephone interview with a MA on 04/28/25 at 7:17pm revealed: -Resident #2 did not have lorazepam PRN. -If Resident #2 had a PRN order for lorazepam she would ask for it. -She asked when she could have her scheduled lorazepam all the time. -Resident #2 could get upset at times but it was usually close to her scheduled medication time, and she would calm down after the lorazepam was administered. Interview with the RCC on 04/29/25 at 04/29/25 revealed Resident #2 did not have an order for lorazepam 0.5mg PRN for anxiety. Interview with the Administrator on 04/29/25 at 4:35pm revealed she was not aware the order for	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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) COMPLETE DATE
D 358	Continued From page 236 Resident #2's lorazepam 0.5mg PRN for anxiety was not implemented. Attempted telephone interview with the pharmacist from the VA pharmacy on 10:35am was unsuccessful. _____ Telephone interview with the Registered Nurse from the VA on 04/29/25 at 9:40am revealed: -Resident #2 was discharged from the VA hospital with new medications because of a concern for polypharmacy. -Resident #2 had an appointment with her PCP at the VA today, 04/29/25 and her medications would be reconciled at the appointment. -The PCP from the VA expected medication orders to be carried out as ordered. Interview with the RCC on 04/28/25 at 9:55am revealed: -Resident #2's medications dispensed from the VA pharmacy were not used because there were already medications on the medication cart for Resident #2 that came from the facility's contracted pharmacy. -There were no orders with the medications that came from the VA pharmacy. -The PCP only signed the paperwork that came in with the medication from the VA as reviewed and decided to keep Resident #2 on all her currently scheduled medications. Refer to the interview with the SCC on 04/25/25 at 9:15am. Refer to the interview with the RCC on 04/29/25 at 5:20pm. Refer to the interview with the Administrator on 04/29/25 at 4:53pm.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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) COMPLETE DATE
D 358	Continued From page 237 2. Review of Resident #3's current FL-2 dated 07/22/24 revealed diagnoses included hypertension, chronic kidney disease, congestive heart failure (CHF), diabetes mellitus type 2, bilateral leg edema, schizophrenia, and kidney failure. a. Review of Resident #3's Primary Care Provider's (PCP) visit note summary dated 03/18/25 revealed: -Resident #3 reported worsening dyspnea (difficulty breathing). -Resident #3 used his inhaler and nebulizer as ordered. -Resident #3 had dyspnea with exertion. -Resident #3's weight was 172 pounds today, 03/18/25. -Resident #3 has had a 60% reduction in ambulation. -Resident #3's chronic obstructive pulmonary disorder (COPD) was managed with daily Breo Ellipta (used to treat COPD) and ipratropium/albuterol (used to treat COPD) nebulizer treatments twice daily. -Despite inhaler and nebulizer treatments, Resident #3 continued with difficulty breathing. -She would consider increasing the frequency of the nebulizer treatments to three times a day and oxygen as needed to alleviate breathing difficulties. -Staff were to continue to administer inhaler and nebulizer treatments as ordered. 1. Review of Resident #3's signed physician order dated 01/21/25 revealed there was an order for Breo Ellipta inhaler 100-25 inhale one puff daily. Review of Resident #3's February 2025 electronic medication administration record (eMAR) revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 358	Continued From page 238 -There was an entry for Breo Ellipta 100-25 inhale one puff daily with a scheduled administration time of 8:00am. -There was documentation that Breo Ellipta 100-25 was administered 26 of 28 opportunities. -There were two exceptions documented; the exception was that Resident #3 was out of the facility. Review of Resident #3's March 2025 eMAR revealed: -There was an entry for Breo Ellipta 100-25 inhale one puff daily with a scheduled administration time of 8:00am. -There was documentation that Breo Ellipta 100-25 was administered 27 of 31 opportunities. -There were 2 exceptions documented; the exception was Resident #3 was out of the facility and there was one blank on the eMAR. Review of Resident #3's April 2025 eMAR from 04/01/25 to 04/22/25 revealed: -There was an entry for Breo Ellipta 100-25 inhale one puff daily with a scheduled administration time of 8:00am. -There was documentation that Breo Ellipta 100-25 was administered 22 of 22 opportunities. Telephone interview with a representative from the facility's contracted pharmacy on 04/28/25 at 9:00am revealed: -The pharmacy had an order for Breo Ellipta 100-25 inhaler one puff daily dated 12/31/24. -The pharmacy dispensed one Breo Ellipta inhaler on 01/31/25, 03/18/25, and 04/17/25; each inhaler would last 30 days. -The inhaler was used to treat asthma or COPD; the inhaler contained a steroid and opened the bronchioles.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 358	Continued From page 239 Observation of Resident #3's medication on hand on 04/22/25 at 12:03pm revealed: -There was a Breo Ellipta inhaler with 9 of 30 inhalations available for administration with a dispensed date of 03/18/25. -There was a second Breo Ellipta inhaler with 30 of 30 inhalations available for administration with a dispensed date of 04/17/25. Interview with Resident #3 on 04/29/25 at 9:20am revealed: -He used his inhaler most days. -He used his inhaler that morning (04/29/25). -He had shortness of breathe when ambulating to the dining room and to get his medications. 2. Review of Resident #3's signed physician orders dated 12/31/24 revealed there was an order for ipratropium/albuterol solution via nebulizer twice daily. Review of Resident #3's February 2025 eMAR revealed: -There was an entry for ipratropium/albuterol solution one vial via nebulizer twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation ipratropium/albuterol solution was administered 51 of 56 opportunities. -There were 5 exceptions documented; the exceptions were resident refused or was out of the facility. Review of Resident #3's March 2025 eMAR revealed: -There was an entry for ipratropium/albuterol solution one vial via nebulizer twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation ipratropium/albuterol	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 358	Continued From page 240	D 358		

solution was administered 58 of 62 opportunities.
-There were 3 exceptions documented; the exceptions were the resident refused or was out of facility and there was one blank on the eMAR.

Review of Resident #3's April 2025 eMAR from 04/01/25 to 04/22/25 revealed:
-There was an entry for ipratropium/albuterol solution one vial via nebulizer twice daily with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation ipratropium/albuterol solution was administered 44 of 44 opportunities.

Telephone interview with a representative from the facility's contracted pharmacy on 04/28/25 at 9:00am revealed:
-Resident #3 had an order for ipratropium/albuterol solution twice daily dated 12/31/24.
-The pharmacy dispensed 60 vials of ipratropium/albuterol on 01/07/25, 03/09/25 and 03/20/25 which would last 30 days.
-There was no ipratropium/albuterol solution dispensed in February 2025.
-The ipratropium/albuterol solution was used to open the bronchioles in residents diagnosed with COPD.

Observation of Resident #3's medication on hand on 04/22/25 at 12:03pm revealed there were 46 of 60 vials of ipratropium/albuterol available for administration; there was no prescription label on the box.

Interview with Resident #3 on 04/29/25 at 9:20am revealed:
-He used the nebulizer one to two times a day.
-He had not used the nebulizer that morning, 04/29/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 358	Continued From page 241 -The medication aide (MA) gave him a vial of medication to place in the nebulizer last night. (he pulled a vial of ipratropium/albuterol from his shirt pocket). -He would place the medication in the nebulizer and administer the medication himself; he did not administer last nights medication. -He would get tired and short of breath walking to the dining room and to the medication cart. -He would sit on his rollator walker and rest when he got tired and short of breath. Interview with a MA on 04/29/25 at 10:15am revealed: -She had not administered Resident #3's nebulizer treatment that morning, 04/29/25. -She did the nebulizer treatment last after she completed the morning medication pass. -She did not give Resident #3 a vial of medication for the nebulizer that morning. -She administered Resident #3 his nebulizer treatments as ordered. -Resident #3 never refused his nebulizer treatments. Interview with a second MA on 04/29/25 at 11:45am revealed: -She passed medications to Resident #3 last night, 04/28/25. -Resident #3 was not ready to do his nebulizer treatment at 8:00pm. -She left the vial of medication with Resident #3 to administer himself. -She did not know Resident #3 did not administer the medication; she did not know if he had a self administration order or not. -She should have returned the vial of medication to the medication cart since Resident #3 was not ready to administer it.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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) COMPLETE DATE
D 358	Continued From page 242 Telephone interview with Resident #3's Primary Care Provider (PCP) on 04/25/25 at 3:00pm revealed: -The nebulizer treatments helped improve shortness of breath and decreased the chance of Resident #3 going into COPD exacerbation. -She expected Resident #3's nebulizer treatments to be administered as ordered. Interview with the Special Care Coordinator (SCC) on 04/25/25 at 9:15am revealed: -If there were more vials of ipratropium/albuterol remaining than there should be, then it appeared Resident #3 was not being administered his nebulizer treatments as ordered. -Resident #3 could have increased respiratory issues if he did not receive his medication as ordered. -When the PCP reviewed the eMARs she would see that the nebulizer treatments were documented as administered. -The PCP could increase the frequency of the nebulizer treatments or order additional medication based on Resident #3 continuing with shortness of breath. -The documentation on the eMAR did not reflect the accurate administration of the nebulizer treatments. -The PCP may think Resident #3 received the nebulizer treatments as ordered and could change Resident #3 medications because he was having shortness of breath. -The medication would not be the problem; the problem was the MAs. Interview with the Administrator on 04/29/25 at 4:53am revealed: -Resident #3 could have breathing problems if he was not administered the medications for COPD	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 243 as ordered. -She expected the MAs to administer medications as ordered. b. Review of Resident #3's signed physician orders dated 12/31/24 revealed there was an order for furosemide 20mg (used to treat fluid retention and CHF) every morning. Review of Resident #3's February 2025 eMAR revealed: -There was an entry for furosemide 20mg every morning with a scheduled administration time of 8:00am. -There was documentation furosemide 20mg was administered 25 of 28 opportunities. -There was one exception documented; the exception was the resident was out of the facility and there was one blank on the eMAR. Review of Resident #3's March 2025 eMAR revealed: -There was an entry for furosemide 20mg every morning with a scheduled administration time of 8:00am. -There was documentation furosemide 20mg was administered 23 of 28 opportunities. -There were 3 exceptions documented; the exception was the resident was out of the facility and there were 2 blanks on the eMAR. Review of Resident #3's April 2025 eMAR from 04/01/25 to 04/22/25 revealed: -There was an entry for furosemide 20mg every morning with a scheduled administration time of 8:00am. -There was documentation furosemide 20mg was administered 20 of 22 opportunities. -There were 2 two blanks on the eMAR.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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) COMPLETE DATE
D 358	Continued From page 244 Telephone interview with a representative from the facility's contracted pharmacy on 04/28/25 at 9:00am revealed: -The pharmacy had an order for furosemide 20mg daily. -The pharmacy dispensed 30 tablets of furosemide on 01/26/25, 02/23/25, and 04/13/25. -Furosemide was used to treat high blood pressure (BP), heart failure and edema. -The facility did not request a refill for furosemide in March 2025. -The facility was responsible for re-ordering medication when there were 5 to 7 tablets remaining in the punch card. -The facility could re-order medications by clicking re-order on the computer, faxing the prescription label, or calling the pharmacy. -The pharmacy would have the medications delivered to the facility in one to two days, unless it was the weekend, when it could take an extra day. Observation of Resident #3's medication on hand on 04/22/25 at 12:04pm revealed there was a punch card with 23 of 30 furosemide 20mg tablets available for administration dispensed on 04/13/25. c. Review of Resident #3's signed physician orders dated 12/31/24 revealed there was an order to administer furosemide 20mg for a weight gain of 2 pounds from the night before or 5 pounds over 5 days. Review of Resident #3's February 2025 eMAR revealed: -There was an entry to obtain weight with a scheduled time of 8:00am and 8:00pm and to administer furosemide 20mg for a weight gain of 2 pounds from the night before or 5 pounds over	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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) COMPLETE DATE
D 358	Continued From page 245 5 days. -There was documentation the resident weighed 156 pounds on 02/24/25 at 8:00pm. -There was documentation the resident weighed 164 pounds on 02/25/25 at 8:00am. -There was no documentation furosemide 20mg was given for a weight gain greater than 2 pounds from 02/24/25 to 02/25/25. Review of Resident #3's March 2025 eMAR revealed: -There was an entry to obtain weight with a scheduled time of 8:00am and 8:00pm and to administer furosemide 20mg for a weight gain of 2 pounds from the night before or 5 pounds over 5 days. -There was documentation that the resident weighed 154 pounds on 03/27/25 at 8:00pm and he weighed 164 pounds on 03/28/25 at 8:00am; there was no documentation that an extra furosemide 20mg was administered for the weight gain of 10 pounds from 03/27/25 to 03/28/25. Review of Resident #3's April 2025 eMAR from 04/01/25 to 04/22/25 revealed: -There was an entry to obtain weight with a scheduled time of 8:00am and 8:00pm and to administer furosemide 20mg for a weight gain of 2 pounds from the night before or 5 pounds over 5 days. -There was documentation that the resident weighed 151 pounds on 04/09/25 at 8:00pm and 154 pounds on 04/10/25 at 8:00am; there was no documentation that furosemide was administered for a weight gain of 9.2 pounds from 04/09/25 to 04/10/25. -There was documentation that the resident weighed 164 pounds on 04/13/25 at 8:00pm and 166.8 pounds on 04/14/25 at 8:00am; there was	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 246	D 358		

no documentation that furosemide was administered for a weight gain of 2.8 pounds.

Telephone interview with a representative from the facility's contracted pharmacy on 04/28/25 at 9:00am revealed:
-There was an order to obtain Resident #3's weight and to administer furosemide 20mg for a weight gain of 2 pounds from the night before or 5 pounds in 5 days dated 12/31/24.
-The pharmacy had not dispensed any additional furosemide to be used for weight gain.
-The facility had not requested any additional furosemide to be used for weight gain.
-The pharmacy would have dispensed a punch card of furosemide 20mg as needed had it been requested by the facility.

Observation of Resident #3's medication on hand on 04/22/25 at 12:04pm revealed there was no punch card for furosemide 20mg for weight gain of 2 pounds from the night before or 5 pounds in 5 days available for administration,

Interview with Resident #3 on 04/22/25 at 11:38am revealed:
-The personal care aide (PCA) checked his weight in the morning and before bed daily.
-He did not know if he received any extra medication if he gained weight.
-He became short of breath when ambulating to the dining room and to the medication cart.

Interview with a MA on 04/25/25 at 11:00am revealed:
-She weighed Resident #3 each morning she worked with him.
-She had not administered an extra dose of furosemide to Resident #3 for weight gain.
-She could not see what the previous weight was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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(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) COMPLETE DATE
D 358	Continued From page 247	D 358		

so she did not know if Resident #3 needed an extra dose of furosemide.
-She had mentioned to the previous Resident Care Coordinator (RCC) that she could not see the weight from the previous day; she had not mentioned it the current RCC.

Interview with a second MA on 04/28/25 at 10:08am revealed:
-She did not weigh Resident #3 that morning.
-She was working the medication cart with an agency MA.
-The agency MA should have weighed Resident #3 that morning.
-The agency MA left after an hour or so.

Interview with a third MA on 04/29/25 at 9:53am revealed:
-The MAs were responsible for obtaining Resident #3's weight.
-The MA would have to go back to the history to see the previous weight to ensure the extra dose of furosemide was to be administered.
-She had not administered an extra dose of furosemide related to weight gain; because she could not see the previous weight.

Telephone interview with Resident #3's PCP on 04/25/25 at 3:00pm revealed:
-Resident #3 could have volume overload which could impact his kidneys, resulting in acute kidney failure or injury to his kidneys if he did not receive his furosemide as ordered.
-The increase in fluid overload could cause shortness of breath.
-She was not aware that Resident #3 did not receive his furosemide as ordered daily or with weight gain.
-She expected the MAs to follow the orders as written and administer the medications as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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) COMPLETE DATE
D 358	Continued From page 248 ordered. Interview with the SCC on 04/25/25 at 9:15am revealed: -She did not know the pharmacy had not dispensed any furosemide to be administered as needed for weight gain. -The MAs should have spoke to someone in management about not having furosemide to administer for weight gain. Interview with the Administrator on 04/29/25 at 8:35am revealed: -She administered medications when a MA did not show up for work. -She had administered medications to Resident #3. -She weighed Resident #3 in the morning when she administered medications. -She did not look on the eMAR to see what Resident #3's weight was the day before. -The previous day's weight could be seen under history on the eMAR. -She did not administer furosemide when Resident #3's gained weight. -She should have administered Resident #3 an extra furosemide 20mg tablet because of Resident #3's weight gain on 04/14/25. -Resident #3 could experience shortness of breath, fluid overload, and possibly hospitalization if he retained too much fluid. d. Review of Resident #3's signed physician orders dated 12/31/24 revealed there was an order for metoprolol 100mg (used for elevated blood pressure) daily. Review of Resident #3's February 2025 eMAR revealed: -There was an entry for metoprolol 100mg daily	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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) COMPLETE DATE
D 358	Continued From page 249	D 358		

with a scheduled administration time of 8:00am.
-There was documentation metoprolol was administered 24 of 28 opportunities.
-There were 3 exceptions documented; the exceptions were the resident refused or the resident was out of facility, and there was one blank on the eMAR.

Review of Resident #3's March 2025 eMAR revealed:
-There was an entry for metoprolol 100mg daily with a scheduled administration time of 8:00am.
-There was documentation metoprolol was administered 26 of 31 opportunities.
-There were 3 exceptions documented; the exception was the resident was out of the facility and there were 2 blanks on the eMAR.

Review of Resident #3's April 2025 eMAR from 04/01/25 to 04/22/25 revealed:
-There was an entry for metoprolol 100mg daily with a scheduled administration time of 8:00am.
-There was documentation metoprolol was administered 20 of 22 opportunities.
-There were 2 blanks on the eMAR.

Telephone interview with a representative from the facility's contracted pharmacy on 04/23/25 at 12:02pm revealed:
-The pharmacy had an order for metoprolol 100mg daily.
-The pharmacy dispensed 30 tablets of metoprolol 100mg on 03/05/25 and 04/07/25.
-The pharmacy did not dispense any metoprolol 100mg in February 2025.

Observation of Resident #3's medication on hand on 04/22/25 at 12:04pm revealed there was a punch card with 24 of 30 metoprolol 100mg tablets available for administration dispensed on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 358	Continued From page 250	D 358		

04/07/25 with documentation on the punch card the first day used was 04/17/25.

Interview with a MA on 04/28/25 at 10:08am revealed:
-She had administered metoprolol 100mg to Resident #3.
-She did not know why Resident #3 had more pills in the punch card than there should be.

e. Review of Resident #3's signed physician order dated 02/11/25 revealed there was an order for metoprolol 25mg daily in addition to metoprolol 100mg tablet. Hold metoprolol 25mg dose when BP was less than 140/90 or heart rate was less than 55 beats per minute.

Review of Resident #3's February 2025 eMAR revealed:
-There was an entry for metoprolol 100mg daily in addition to metoprolol 25mg. Hold metoprolol 25mg when BP was less than 140/90.
-There was documentation on 02/26/25 the BP reading was 128/74 and metoprolol 25mg was administered.

Review of Resident #3's March 2025 eMAR revealed:
-There was an entry for metoprolol 100mg daily in addition to metoprolol 25mg. Hold metoprolol 25mg when BP was less than 140/90.
-There was documentation on 03/16/25 the BP reading was 122/76 and metoprolol 25mg was administered.
-There was documentation on 03/17/25 the BP reading was 122/76 and metoprolol 25mg was administered.
-There was no documentation of a BP reading on 03/01/25 and 03/29/25; the eMAR was blank.
-There was no documentation that metoprolol

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 358	Continued From page 251 25mg was administered on 03/01/25 and 03/29/25; the eMAR was blank. Review of Resident #3's April 2025 eMAR from 04/01/25 to 04/22/25 revealed: -There was an entry for metoprolol 100mg daily in addition to metoprolol 25mg. Hold metoprolol 25mg when BP was less than 140/90. -There was documentation on 04/12/25 the BP reading was 127/77 and metoprolol 25mg was administered. -There was documentation on 04/14/25 the BP reading was 99/59 and metoprolol 25mg was administered. -There was documentation on 04/17/25 the BP reading was 120/79 and metoprolol 25mg was administered. -There was documentation on 04/19/25 the BP reading was 128/69 and metoprolol 25mg was administered. Telephone interview with a representative from the facility's contracted pharmacy on 04/23/25 at 12:02pm revealed: -The pharmacy had an order for metoprolol 25mg in addition to metoprolol 100mg daily; hold metoprolol 25mg if BP was less than 140/90 dated 02/11/25. -The pharmacy dispensed 30 tablets of metoprolol 25mg on 02/12/25 and 03/28/25. Observation of Resident #3's medication on hand on 04/22/25 at 12:04pm revealed there was a punch card with 16 of 30 metoprolol 100mg available for administration dispensed on 03/28/25. Interview with Resident #3 on 04/22/25 at 11:38am revealed: -The MA checked his BP two times a day.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 358	Continued From page 252 -He took medication for his blood pressure but he did not know the name of the medication. -Some days he felt tired, but he did not have dizzy spells. Interview with a MA on 04/28/25 at 10:08am revealed: -She checked Resident #3's BP that morning and recorded it in the eMAR. -She did not recall what Resident #3's BP reading was but she did not hold metoprolol 25mg. -She had never held Resident #3's metoprolol 25mg because of his BP reading. -She should have held Resident #3's metoprolol 25mg on the days his BP was below 140/90. -She needed to pay more attention. Interview with a second MA on 04/29/25 at 9:53am revealed: -The MAs were responsible for obtaining Resident #3's BP daily. -She did not recall holding Resident #3's metoprolol 25mg. -She should have held Resident #3's BP when it was below 140/90; she made a mistake. Interview with a third MA on 04/29/25 at 10:05am revealed: -Resident #3's metoprolol 25mg should be held for his BP less than 140/90. -She had taken Resident #3's BP several times when it was less than 140/90 and failed to hold metoprolol 25mg. -She made a mistake and should have held the medication. Telephone interview with Resident #3's PCP on 04/25/25 at 3:00pm revealed: -Resident #3's metoprolol 25mg should be held if the BP reading was less than 140/90.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 253 -Resident #3 also took metoprolol 100mg; if metoprolol 25mg was not held when the BP reading was less than 140/90 then the BP could drop and Resident #3 could have hypotension causing dizziness, syncope, and falls. -She expected the MAs to hold metoprolol 25mg if Resident #3's BP reading was below 140/90. Interview with the Administrator on 04/29/25 at 4:53am revealed: -The MA should hold metoprolol 25mg when Resident #3's BP was less than 140/90. -Resident #3's BP could drop and he could have dizziness. Refer to the interview with the SCC on 04/25/25 at 9:15am. Refer to the interview with the RCC on 04/29/25 at 5:20pm. Refer to the interview with the Administrator on 04/29/25 at 4:53pm. 3. Review of Resident #6's current FL-2 dated 12/31/24 revealed diagnoses included dementia, schizoaffective disorder, Alzheimer's disease, neuropathy, and hypertension. Review of Resident #6's Primary Care Provider's (PCP) visit note dated 12/06/24 revealed: -Resident #6 reported left hip pain with onset 4 days prior to today's visit (12/06/24). -No falls were reported, and Resident #6 was able to ambulate on exam without pain. -There was no bruising or redness on the left hip. -Resident #6 reported that he was receiving Tylenol (used to treat pain) for the hip pain and the pain was being managed. -The physician was to be called if the pain	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 358	Continued From page 254	D 358		

worsened; imaging of the left hip would be considered if the pain persisted.

Review of Resident #6's PCP visit note dated 12/17/24 revealed:
-Resident #6 complained of mild chest wall pain which started today, 12/17/24.
-Resident #6 denied the chest pain radiated.
-The PCP ordered lidocaine patch (used to treat pain) daily to be applied to Resident #6's chest wall.

Review of Resident #6's hospital discharge summary dated 12/29/24 revealed:
-Resident #6 was seen in the Emergency Department (ED) on 12/28/24 for chest pain and abdominal pain and admitted to the hospital.
-The chest x-ray on 12/28/24 revealed an upper lobe mass in his right lung.
-The computed tomography (CT) scan completed on 12/28/24 showed a nodule on the right adrenal gland, probably metastatic; a nodule on the right kidney, likely metastatic; and a mass in the right iliac bone, likely metastatic without pathological fracture.

Telephone interview with Resident #6's Power of Attorney (POA) on 04/24/25 at 8:32am revealed:
-Resident #6 was transferred to the hospital on 03/03/25 with swelling of his legs and pain.
-He was transferred to a hospice facility where he passed away on 03/11/25.

a. Review of Resident #6's signed physician order dated 01/08/25 revealed there was an order for oxycodone 5mg (used to treat severe pain) on tablet every 6 hours as needed (PRN) for pain.

Review of Resident #6's signed physician order dated 02/03/25 revealed there was an order for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 255 oxycodone 5mg 2 tablets every 6 hours as PRN for pain. Review of Resident #6's signed physician order dated 02/06/25 revealed there was an order for oxycodone 5mg 2 tablets every 4 hours PRN for pain. Review of Resident #6's February 2025 electronic medication administration record (eMAR) from 02/01/25 to 02/28/25 revealed: -There was an entry for oxycodone 5mg two tablets every 6 hours PRN for pain. -There was no documentation oxycodone 5mg two tablets (10mg) were administered from 02/04/25 to 02/05/25. -There was an entry on 02/6/25 for oxycodone 5mg two tablets every 4 hours PRN for pain. -There was documentation oxycodone 5mg two tablets were administered on 02/06/25. 02/07/25 and twice on 02/10/25. -There was documentation Resident #6 was out of the facility from 02/01/25 to 02/03/25; he returned to the facility on 02/04/25. Review of Resident #6's January 2025 controlled substance count sheet (CSCS) for oxycodone 5mg tablets revealed: -There was documentation that one oxycodone 5mg tablet was signed out on 02/06/25, 02/07/25 and on 02/10/25 at 8:00pm and on 02/10/25 with no time documented. -There was no documentation that a second oxycodone 5mg tablet was signed out on 02/06/25, 02/07/25 and 02/10/25, to administer 10mg as ordered. Telephone interview with a representative from the facility's contracted pharmacy on 04/23/25 at 3:11pm revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 256 -The pharmacy had an order for oxycodone 5mg one tablet every 6 hours PRN for pain dated 01/09/25. -The pharmacy dispensed 20 oxycodone 5mg tablets on 01/09/25. -The pharmacy received a second order for oxycodone 5mg two tablets every 6 hours as PRN for pain on 02/03/25. -The pharmacy dispensed 30 oxycodone 5mg tablets on 02/03/25. -The pharmacy received a third order for oxycodone 5mg two tablets every 4 hours PRN for pain on 02/06/25. -The pharmacy dispensed 18 oxycodone 5mg tablets on 02/06/25 and 60 oxycodone 5mg tablets on 02/18/25. Observation of Resident #6's medication on hand on 04/24/25 at 2:11pm revealed there was a punch card with 13 of 60 oxycodone 5mg tablets available for administration dispensed on 02/18/25. Telephone interview with Resident #6's Power of Attorney (POA) on 04/24/25 at 8:32am revealed: -Sometimes Resident #6 would only get one oxycodone 5mg tablet when he was ordered two. -She was visiting Resident #6 one day when the medication aide (MA) gave him one oxycodone for pain. -She spoke to the MA about giving him two oxycodone, -The MA did not realize Resident #6 had a new order for two oxycodone 5mg tablets. Interview with Resident #6's former roommate on 04/28/25 at 4:22pm revealed: -Resident #6 complained of pain most of the time. -Resident #6 would go to the medication cart and beg for his pain medication.	D 358		

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	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 358	Continued From page 257 -He overheard a staff say, they refused to give Resident #6 the oxycodone because he was faking his pain. -He overheard another staff member say, she did not want to be responsible for the narcotic so she would not administer it. -Several MAs refused to give him his pain medication. -Resident #6 would lie in bed and cry out for his pain medication. -Resident #6 moaned and groaned a lot. -He told the MAs he thought Resident #6 was in pain; the MAs seemed as if they did not care. Interview with a MA on 04/25/25 at 11:00am revealed: -She documented PRN controlled substances on the CSCS; she did not have to document PRN controlled substances on the eMAR. -She was told to only document the PRN controlled substances on the CSCS sheet; she did not remember who told her. -She did not realize the order had changed from one 5mg tablet to two 5mg tablets every 4 hours. -She needed to pay closer attention. Interview with the Resident Care Coordinator (RCC) on 04/23/25 at 10:35am revealed: -Resident #6 was sent to the hospital in January 2025 because of pain. -Resident #6 was diagnosed with bone cancer and the cancer caused a fractured femur. -Resident #6 had a total hip replacement and went to rehabilitation before returning to the facility the first week of February 2025. -Resident #6 always complained of pain and was ordered oxycodone PRN for break through pain. b. Review of Resident #6's signed physician order dated 02/13/25 revealed there was an order for	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 258 morphine 15mg extended release (ER) tablet (used for severe pain) every 8 hours. Review of Resident #6's February 2025 eMAR from 02/13/25 to 02/28/25 revealed: -There was an entry for morphine 15mg ER every 8 hours with a scheduled administration time of 6:00am, 2:00pm, and 10:00pm. -There was documentation that morphine 15mg ER was not administered due to awaiting insurance authorization from 02/13/25 to 02/20/25. -There was documentation that morphine 15mg ER was administered 20 times out of 25 times from 02/20/25 at 10:00pm to 02/28/25 at 10:00pm. -There were exceptions documented on 02/26/25 and 02/28/25 at 6:00am; the exception was Resident #6 was sleeping. Review of Resident #6's February 2025 CSCS for morphine 15mg ER tablets revealed: -The dispense date was 02/14/25 for 90 morphine 15mg ER tablets, one tablet every 8 hours. -There was documentation that 32 morphine 15mg ER tablets were signed out for administration from 02/15/25 to 02/28/25. -On 02/15/25 at 10:00pm, there was no documentation of removal of one morphine tablet. -On 02/16/25 at 6:00am, 2:00pm, or 10:00pm, there was no documentation of removal of one morphine tablet. -On 02/17/25 at 10:00pm, there was no documentation of removal of one morphine tablet. -On 02/18/25 at 10:00pm, there was no documentation of removal of one morphine tablet. -On 02/20/25 at 2:00pm, there was no documentation of removal of one morphine tablet. -On 02/25/25 at 10:00pm, there was no	D 358		

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D 358	Continued From page 259	D 358		

documentation of removal of one morphine tablet.
-On 02/26/25 at 6:00am, there was no documentation of removal of one morphine tablet.
-On 02/28/25 at 6:00am, there was no documentation of removal of one morphine tablet.

Review of Resident #6's March eMAR from 03/01/25 to 03/03/25 revealed:
There was an entry for morphine 15mg ER every 8 hours with a scheduled administration time of 6:00am, 2:00pm, and 10:00pm.
-There was documentation that morphine 15mg ER was administered 6 out of 9 times.
-There were no exceptions documented on 03/01/25 at 2:00pm, 03/03/23 at 6:00am, and 03/04/25 at 2:00pm; the eMAR was blank.

Review of Resident #6's March 2025 CSCS for morphine 15mg ER tablets revealed:
-There was documentation that 6 morphine 15mg ER tablets were signed out for administration from 03/01/25 to 03/03/25.
-On 03/01/25 at 10:00pm, there was no documentation of removal of one morphine tablet.
-On 03/02/25 at 2:00pm, there was no documentation of removal of one morphine tablet.
-On 03/03/25 at 6:00am, there was no documentation of removal of one morphine tablet.

Telephone interview with a representative from the facility's contracted pharmacy on 04/23/25 at 3:11pm revealed:
-The pharmacy had an order for morphine 15mg ER every 8 hours.
-The pharmacy dispensed 90 morphine 15mg ER tablets on 02/14/25.

Observation of Resident #6's medication on hand on 04/24/25 at 2:11pm revealed there was a punch card with 52 of 90 morphine 15mg ER

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 260	D 358		

tablets available for administration dispensed on 02/14/25.

Interview with a MA 04/28/25 at 5:20pm revealed:
-Resident #6 was ordered pain medication because he had cancer.
-She always gave Resident #6 his pain medication as ordered.
-When she gave Resident #6 his scheduled pain medication, she would document on the eMAR and the CSCS.
-She did not know she had not administered Resident #6 his scheduled morphine as ordered.

Interview with another MA on 04/29/25 at 10:15am revealed:
-Resident #6 had terminal cancer.
-Resident #6 broke his hip because of the cancer and he was in a lot of pain.
-Resident #6 was sent to the hospital and had a hip replacement and then to rehabilitation before returning to the facility.
-When he returned he was still in a lot of pain.
-She administered morphine to Resident #6; it was a scheduled dose every 8 hours.
-She did not miss giving Resident #6 his 10:00pm dose of morphine twice in February 2025 because she did not work past 8:00pm.
-She did not know who missed the two doses of morphine or how her initials were on the eMAR as having administered the morphine.

Interview with the RCC on 04/23/25 at 10:35am revealed:
-Resident #6 was sent to the hospital in January 2025 because of pain.
-Resident #6 was diagnosed with bone cancer and the cancer caused a fractured femur.
-Resident #6 had a total hip replacement and went to rehabilitation before returning to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 261 facility the first week of February 2025. -Resident #6 always complained of pain and was ordered morphine. _____ Telephone interview with Resident #6's POA on 04/24/25 at 8:32am revealed: -Resident #6 was taken to the hospital on 12/28/24 for pain. -He was given pain medication and returned to the facility on 12/29/24. -Around the first week of January 2025, Resident #6 complained of hip pain and returned to the hospital. -He was given pain medication and returned to the facility. -Three days after returning from the hospital, Resident #6 could not stand up due to the pain in his left hip. -She spoke to Resident #6's PCP and requested Resident #6 to be sent to the hospital. -The chest x-rays showed Resident #6 had a mass on his right lung, his left hip, on his adrenal gland, both sides of his heart, and the thoracic 9 vertebra, which was fractured. -Resident #6 was diagnosed with a pathological left hip fracture due to cancer. -Resident #6 was transported to a larger hospital and had a complete hip replacement. -After 5 days in the hospital, he was transported to a rehabilitation center for 10 days before returning to the Assisted Living (AL) facility. -He was ambulating about 50 yards when he returned to the AL facility on 02/04/25. -She helped Resident #6 get settled in his room and his bed when Resident #6 returned to the facility after rehabilitation. -She asked the MA to give Resident #6 his pain medication. -The MA said Resident #6 had to come to the medication cart to get his medications.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 262 -She informed the MA that Resident #6 was settled in bed and would not come to the medication cart to get medications. -The MA said she guessed she could walk to his room and give him his medication. -On 02/09/25, she took Resident #6 to the oncologist because he had swelling in his legs. -The oncologist told Resident #6 that if he stood, he could break his legs because of bone cancer. -Resident #6 would call her 5 to 6 times a day crying and begging for help because the pain was so bad. -Resident #6 said he was not getting his medication because he could not walk to the medication cart. -Resident #6 told her not to say anything because the staff would treat him worse than they already do. -Resident #6 called her on 02/14/25 begging for his pain medication; he had not had his pain medication all day. -Resident #6 told her there was no MA in the facility. -She called the facility and spoke to a PCA, who told her she could not give Resident #6 his medication because she was not a MA and there was no MA working to administer medications. -She called the previous Administrator and did not get an answer. -She called the previous RCC, who was out sick, and told her there was no MA in the facility to administer medications. -The previous RCC told her she would get a MA in the facility. -She was told a MA went to the facility at 2:30am on 02/15/25. Telephone interview with Resident #3's PCP on 04/25/25 at 3:00pm revealed: -Resident #6 had lung cancer that metastasized	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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) COMPLETE DATE
D 358	Continued From page 263	D 358		

to his bones.
-She expected the pain medication to be administered as ordered to ensure Resident #6 was comfortable.

Interview with the RCC on 04/28/25 at 2:46pm revealed:
-Resident #6 had terminal bone cancer.
-Resident #6 complained of pain all the time; all he wanted was his pain medication.
-She was not aware the MAs did not administer Resident #6 his pain medication as ordered.
-She told the staff that it was not their decision to decide his pain level and to administer his pain medication when he asked if it was the correct time for administration.

Interview with the Administrator on 04/29/25 at 4:53pm revealed the MAs were expected to administer medications as ordered.

Attempted telephone interviews with two previous MAs on 04/24/25 at 10:32am and 10:35am were unsuccessful.

Attempted telephone interview with the previous RCC on 04/24/25 at 9:28am was unsuccessful.

Refer to the interview with the Special Care Coordinator (SCC) on 04/25/25 at 9:15am.

Refer to the interview with the RCC on 04/29/25 at 5:20pm.

Refer to the interview with the Administrator on 04/29/25 at 4:53pm.

4. Review of Resident #1's FL-2 dated 12/21/24 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 358	Continued From page 264 -Diagnoses included dementia, schizoaffective disorder, hypertension, and a history of cerebrovascular disease (CVA). -There was an order for metoprolol tartrate (used to treat high blood pressure) 100mg, take two tablets to equal 200mg twice daily, hold if systolic blood pressure (SBP) was less than 110. Review of Resident #1's signed physician's orders dated 04/01/25 revealed an order for metoprolol tartrate 100mg, take two tablets to equal 200mg twice daily, and hold if SBP was less than 110. Review of Resident #1's February 2025 electronic medication administration record (eMAR) revealed: -There was an entry for metoprolol tartrate 100mg, take two tablets twice daily, hold if SBP was less than 110 scheduled at 8:00am and 8:00pm. -Metoprolol tartrate was not documented as administered on 02/09/25-02/11/25 at 8:00am and 8:00pm and on 02/12/25 at 8:00am with the exception documented as waiting on pharmacy for refill. -Resident #1's SBP at 8:00am on 02/09/25 was documented as 119 and on 02/10/25 was documented as 149. -There were no SBP documented at 8:00pm. -Metoprolol tartrate was not documented as administered on 02/14/25 at 8:00pm with the exception documented as the resident was sleeping. -Metoprolol tartrate was not documented as administered on 02/15/25 at 8:00pm; there was no exception documented and no SBP documented. -On 02/28/25 at 8:00pm, Resident #1's metoprolol tartrate was documented as held per	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 358	Continued From page 265	D 358		

primary care provider (PCP) order; there was no SBP documented.
-There was an entry for Resident #1's BP and heart rate to be checked daily at 8:00am.
-Resident #1's BP ranged from 111/65-149/100 and her heart rate ranged from 61-104.

Review of Resident #1's March 2025 eMAR revealed:
-There was an entry for metoprolol tartrate 100mg, take two tablets to equal 200mg twice daily, hold if SBP was less than 110 scheduled at 8:00am and 8:00pm.
-Metoprolol tartrate was not documented as administered at 8:00pm on 03/03/25, 03/04/25, 03/10/25, 03/12/25, 03/14/25, 03/21/25, 03/24/25, 03/26/25, and 03/30/25 with the exception documented as held per PCP order; her SBPs were documented as 134, 142, 111, 140, 119, 116, 116, 124, and 145.
-Metoprolol tartrate was not documented as administered at 8:00pm on 03/06/25 and 03/28/25 with the exception documented as held per PCP order; there was no SBP documented for these dates.
-There was an entry for Resident #1's BP and heart rate to be checked daily at 8:00am.
-Resident #1's BP ranged from 86/52-144/98 and her heart rate ranged from 61-82.

Review of Resident #1's April 2025 eMAR from 04/01/25-04/22/25 revealed:
-There was an entry for metoprolol tartrate 100mg, take two tablets to equal 200mg twice daily, hold if SBP was less than 110 scheduled at 8:00am and 8:00pm.
-Metoprolol tartrate was not documented as administered at 8:00pm on 04/02/25, 04/04/25, 04/09/25, 04/11/25, 04/14/25, 04/18/25, and 04/21/25 with the exception documented as held

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 358	Continued From page 266	D 358		

per PCP order; her SBPs were documented as 132, 132, 130, 123, 119, 128, and 121.
-Metoprolol tartrate was not documented as administered at 8:00pm on 04/16/25 with the exception documented as held per PCP order; there was no SBP documented for this date.
-There was an entry for Resident #1's BP and heart rate to be checked daily at 8:00am.
-Resident #1's BP ranged from 115/81-158/98 and her heart rate ranged from 65-80.

Observation of Resident #1's medications on hand on 04/22/25 at 11:52am revealed:
-There was a punch card dispensed on 04/18/25 for metoprolol tartrate 100mg labeled as card 1 of 2, with the directions to take 2 tablets twice daily and hold if the SBP was less than 110; there were 55 of 60 tablets remaining on the punch card.
-There was a second punch card dispensed on 04/18/25 for metoprolol tartrate 100mg labeled as card 2 of 2, with the directions to take 2 tablets twice daily and hold if the SBP was less than 110; there were 60 of 60 tablets remaining on the punch card.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 04/23/25 at 9:56am revealed:
-Resident #1's current order was for metoprolol 100mg, take 2 tablets twice daily and hold if the SBP was less than 110.
-A one-month supply, (120 tablets) of metoprolol 100mg was dispensed on 02/12/25, 03/25/25, and 04/18/25.
-If Resident #1's metoprolol was not administered as ordered, the resident could experience headaches, and dizzy spells, which would also increase the resident's risk of falling.
-Resident #1's metoprolol was a high dosage so the resident's BP must be "bad."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 358	Continued From page 267 -The resident could also experience chest pain and an increased heart rate if her metoprolol was held when it should have been administered per the order. Interview with a medication aide (MA) on 04/24/25 at 3:36pm revealed: -She administered Resident #1's 8:00pm medications. -If Resident #1's SBP was below 110 she administered metoprolol. -If Resident #1's SBP was more than 110 she held the metoprolol. -She had not had to administer Resident #1's metoprolol since she had been working on the medication cart because Resident #1's SBP was usually more than 110. Interview with the Special Care Unit Coordinator (SCC) on 04/24/25 at 4:45pm revealed: -She had been doing eMAR audits to check for holes in the eMAR and to ensure medications were being administered, but she had not looked at the BPs for Resident #1 related to the metoprolol. -She was concerned the MA was administering medication without reading the order correctly. -Not administering Resident #1's metoprolol put the resident in danger because the medication would not be effective for the reason it was ordered. -The PCP would also not be able to "get an accurate picture" to see if the medication was effective if it had not been administered correctly. Telephone interview with Resident #1's PCP on 04/25/25 at 9:53am revealed: -Resident #1 had hypertension and a history of a CVA. -metoprolol was ordered to lower Resident #1's	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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) COMPLETE DATE
D 358	Continued From page 268 BP. -If Resident #1's metoprolol was not being administered as ordered, the resident's BP may not be adequately controlled, which put her at risk for another CVA. Interview with the Administrator on 04/29/25 at 4:53pm revealed: -She was not aware Resident #1's metoprolol was not administered as ordered. -If Resident #1's metoprolol was not administered as ordered it could be detrimental for the resident. Observation of Resident #1's BP on 04/25/25 at 11:19am revealed a BP of 120/69 and a heart rate of 69. Attempted telephone interview with Resident #1's family member on 04/25/25 at 9:47am was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable. Refer to the interview with the SCC on 04/25/25 at 9:15am. Refer to the interview with the RCC on 04/29/25 at 5:20pm. Refer to the interview with the Administrator on 04/29/25 at 4:53pm. 5. Review of Resident #4's FL-2 dated 01/28/25 revealed diagnoses included hypertension and dementia with behavioral disturbance. a. Review of Resident #4's FL-2 dated 01/28/25 revealed an order for quetiapine (an antipsychotic	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 358	Continued From page 269	D 358		

medication used to treat schizophrenia) 100mg, take ½ tablet once daily at 2:00pm.

Review of Resident #4's signed physician's orders dated 04/01/25 revealed an order for quetiapine 100mg, take ½ tablet once daily at 2:00pm.

Review of Resident #1's March 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for quetiapine 100mg, take ½ tablet once daily at 2:00pm.
-Quetiapine 100mg, take ½ tablet, to equal 50mg daily, was not documented as administered from 03/23/25-03/31/25 at 2:00pm with the exception documented as waiting on pharmacy for refill.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 04/23/25 at 9:56am revealed:
-Resident #4's current order was for quetiapine 100mg, take ½ tablet once daily at 2:00pm.
-A one-month supply, 30 one-half tablets of quetiapine 100mg, were dispensed on 02/11/25, 03/07/25, and 03/30/25.
-He checked the inventory and the medication for each dispensing was sent in a tote to the facility.

Telephone interview with Resident #4's mental health provider (MHP) on 04/25/25 at 4:50pm revealed:
-The facility staff had reported to her that Resident #4 was having more agitation and anxiety.
-If Resident #4 was not getting his quetiapine as ordered may be why he was agitated and anxious.
-She had ordered buspar (a medication used to treat anxiety) for Resident #4 on 04/04/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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) COMPLETE DATE
D 358	Continued From page 270	D 358		

because of the increased agitation and anxiety.
-"Maybe" Resident #4 did not need the buspar, she would need to know if the behaviors were from not getting the medication as ordered or changes in his behavior.

Interview with a medication aide (MA) on 03/24/25 at 3:40pm revealed:
-She did not recall anything about Resident #4's quetiapine not being available to be administered.
-If a medication was not on the medication cart to be administered, it would be documented, and the pharmacy would be notified.

Interview with the Special Care Unit Coordinator (SCC) on 04/25/25 at 10:49am revealed:
-She was not aware Resident #4's quetiapine was documented as not available to be administered for 9 days.
-There had been times the pharmacy would say they delivered medication, and the medication did not make it to the medication cart.
-If a medication was not on the cart to be administered, the MA should call the pharmacy.
-If there was an issue with the medication not being delivered, the MA should let someone in management know to assist.
-The medication could be obtained from the backup pharmacy if needed; this process was just implemented about one week ago.

Interview with the Administrator on 04/29/25 at 4:53pm revealed;
-Resident #4's quetiapine should have been reordered when there were 8 tablets remaining on the punch card.
-If Resident #4's quetiapine was not on the medication cart, the MA should have called the pharmacy to see if a new prescription was needed or to see what was needed to get the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 358	Continued From page 271	D 358		

medication into the facility.
-She was concerned Resident #4 missed his medications ordered by his MHP because he could have agitation, anxiety, and aggression from not getting his medications timely.

Attempted telephone interview with another MA on 04/28/25 at 7:52pm was unsuccessful.

b. Review of Resident #4's FL-2 dated 01/28/25 and physician's orders dated 04/01/25 revealed there was no order for lorazepam (used to treat anxiety) 0.5mg

Review of Resident #4's January 2025 from 01/16/25-01/31/25, February 2025, March 2025 and April 2025 from 04/01/25-04/22/25 electronic medication administration record (eMAR) revealed:
-There was no entry for lorazepam 0.5mg.
-There was no documentation lorazepam 0.5mg had been administered.

Review of Resident #4's controlled substance count sheet (CSCS) revealed:
-There were 90 tablets of lorazepam 0.5mg take one tablet every 6 hours as needed (PRN) for anxiety dispensed on 11/14/24 for Resident #4.
-There were 10 tablets documented as administered in January 2025 from 01/23/25-01/31/25.
-There were 10 tablets documented as administered in February 2025 from 02/01/25-02/28/25.
-There were 15 tablets documented as administered in March 2025 from 03/01/25-03/31/25.
-There were 5 tablets documented as administered in April 2025 from 04/01/25-04/22/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 358	Continued From page 272 Observation of Resident #4's medications on hand on 04/23/25 at 10:59am revealed: -There was a punch card of lorazepam 0.5mg with the directions to take one tablet every 6 hours as needed for anxiety. -There were 34 of 90 tablets on hand. Telephone interview with a pharmacist with the facility's contracted pharmacy on 04/23/25 at 9:56am revealed: -Resident #4 did not have a current order for lorazepam 0.5mg. -lorazepam 0.5mg was dispensed for Resident #4 on 11/14/24 with the directions to administer every 6 hours as needed. -The order for Resident #4's lorazepam 0.5mg was discontinued on 12/19/24 after a hospitalization. -The punch card dated 11/14/24 should have been returned to the pharmacy when the medication was discontinued. Telephone interview with Resident #4's mental health provider (MHP) on 04/25/25 at 4:50pm revealed: -She did not have lorazepam listed as a medication being administered to Resident #4. -She would not order lorazepam for Resident #4. -Instead of helping, lorazepam could cause more confusion, increased drowsiness, and could increase the risk of falls. -She was concerned that she did not know what Resident #4 was taking and what to monitor for effectiveness. Interview with a medication aide (MA) on 04/24/25 at 8:57am revealed: -If Resident #4 was agitated she administered his PRN lorazepam.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 358	Continued From page 273 -The first time she administered the lorazepam she popped the medication out, signed it out on the CSCS and when she went into the eMAR she saw the medication was not listed. -She had told the Special Care Unit Coordinator (SCC) there was no entry for lorazepam on the eMAR a "few days ago." Interview with the SCC on 04/24/25 at 4:45pm revealed: -She was not aware Resident #4 did not have an order for lorazepam 0.5mg PRN. -The MAs should look at the eMAR before administering any medication. -The MAs could not administer medication based on a medication label. -There could be a reason Resident #4's lorazepam was discontinued, and it could be harmful for the medication to be administered. -The MAs did not know why the medication should have been discontinued and the medication should not have been administered. -It was also not good because Resident #4's providers would not know what he was being administered. Interview with the Administrator on 04/29/25 at 4:53pm revealed; -She was not aware Resident #4's lorazepam had been administered without an order. -The lorazepam being administered to Resident #4 should have been discontinued before he was admitted to the facility. -The MA should not administer medication if there was no entry on the eMAR. -The MA should have called the pharmacy to see if there was an active order or not. c. Review of Resident #4's FL-2 dated 01/28/25 revealed an order for melatonin (used to aide with	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 358	Continued From page 274	D 358		

sleep) 5mg take one tablet daily.

Review of Resident #4's signed physician's orders dated 04/01/25 revealed an order for melatonin 5mg take one tablet daily.

Review of Resident #4's April 2025 electronic medication administration record (eMAR) from 04/01/25-04/22/25 revealed:
-There was an entry for melatonin 5mg take one tablet daily scheduled at 6:00pm.
-Melatonin 5mg was documented as administered at 6:00pm on 04/01/25, 04/03/25-04/21/25; there were 20 doses documented.
-There was an exception documented on 04/02/25 as the resident refused.

Observation of Resident #4's medications on hand on 04/22/25 at 3:16pm revealed there was a punch card dispensed on 03/30/25 of melatonin 5mg with a handwritten note as opened on 04/01/25 at 4:18pm; there was 1 of 30 tablets remaining on the punch card.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 04/23/25 at 9:56am revealed:
-Resident #4's current order was for melatonin 5mg once daily.
-A one month supply, 30 tablets of melatonin 5mg, were dispensed on 01/24/25, 02/12/25, and 03/30/25.

Telephone interview with Resident #4's mental health provider (MHP) on 04/25/25 at 4:50pm revealed:
-Resident #4 had insomnia which was why the melatonin was ordered.
-There was no negative outcome for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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) COMPLETE DATE
D 358	Continued From page 275 administering more melatonin than was ordered. Interview with a medication aide (MA) on 03/24/25 at 3:40pm revealed: -She did not know why more melatonin was popped from the punch card than should be based on the dispensed/opened date. -She only administered Resident #4 one tablet of melatonin when she administered his medications. Interview with the Special Care Unit Coordinator (SCC) on 04/24/25 at 4:45pm revealed she was concerned Resident #4 had missing tablets of melatonin because it could indicate the resident was receiving more than ordered or the medication was being administered to another resident. Interview with the Administrator on 04/29/25 at 4:53pm revealed: -She was not aware Resident #4's melatonin was missing more tablets than should have been based on the date the medication was opened. -She was concerned the resident was not getting the medication as ordered and it could be detrimental to his health. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable. Refer to the interview with the SCC on 04/25/25 at 9:15am. Refer to the interview with the RCC on 04/29/25 at 5:20pm. Refer to the interview with the Administrator on 04/29/25 at 4:53pm.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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) COMPLETE DATE
D 358	Continued From page 276 Interview with the SCC on 04/25/25 at 9:15am revealed: -Medication cart audits were done on Monday, Wednesday, and Friday. -She and a MA worked together to audit a medication cart. -She would print the orders and call off the name of the medication listed on the order sheet and the MA would make sure the medication was in the medication cart. -If the medication was not in the medication cart, it would be reordered at that moment. -They did not check to see if other medications for a resident were on the medication cart; they should have and then checked for an order for the medication. -Dispensed dates were not checked during the medication cart audit. -When a medication was getting low the MAs were to re-order the medication. -Orders that were brought in the facility from an outside physician's visit would be faxed to the pharmacy by the MA who received the orders upon return of the resident. -She attached the confirmation sheet to the faxes she sent to the pharmacy, but she did not know if everyone did. -The MAs should be reading the medication order on the eMAR; everyone was so rushed when administering medications because MAs did not show up for work or they were late. Interview with the RCC on 04/29/25 at 5:20pm revealed: -She tried to do medication pass observations twice a week, but she did not have time to do them. -She would try to audit the cart when she administered medications to ensure all the	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 358	Continued From page 277	D 358		

medications were on the medication cart.
-When she worked on the medication cart, she observed the other MA administering medications.

Interview with the Administrator on 04/29/25 at 4:53pm revealed:
-The MAs should pass medications based on the 6 rights; right resident, right medication, right dose, right time, and there was one more.
-The RCC and SCC observed one MA pass medications once a week to ensure medications were administered correctly.

_____

The facility failed to administer medications as ordered including a resident who had history of anxiety, chronic nerve pain, diabetes, and trouble sleeping and was not administered multiple doses of her anxiety medication, nerve pain medication, or a sedative for sleep and she was ordered insulin before meals to prevent a spike in her blood sugar and her insulin was not administered as ordered (#2). Resident #3, who was diagnosed with COPD and complained of shortness of breath with exertion was not administered nebulizer treatments or an inhaler and the resident had an order to obtain weights and administer an extra dose of a diuretic with weight gain that was not administered for weight gain of 2 to 13 pounds (#3). Resident #6, who had terminal cancer, cried out in pain, and did not receive his scheduled morphine 9 times in 16 days or his PRN pain medication when requested and Resident #4 was not administered his antipsychotic medication for 9 days and had an increase in agitation and anxiety and the mental health provider ordered an additional antipsychotic medication not knowing that he had missed the other medication. This failure resulted in serious neglect which constitutes a

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D 358	Continued From page 278 Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/23/25 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MAY 29, 2025.	D 358		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by:	D 367		

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	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 367	Continued From page 279 Based on observations, record reviews, and interviews, the facility failed to ensure the electronic medication administration records (eMAR) were accurate for 1 of 1 sampled residents (#5) including a pain patch, an anti-anxiety medication, and a sleep aide (#5). Review of Resident # 5's current FL-2 dated 12/31/24 revealed diagnoses included schizophrenia, hypertension, and constipation. Review of Resident #5's Primary Care Provider's (PCP) visit summary dated 02/11/25 revealed: -Resident #5 complained of intermittent left elbow pain. -There was no obvious injury, redness, or bruising noted. -Lidocaine patches (used to relieve nerve pain) were ordered for pain. a. Review of Resident #5's signed physician order dated 02/13/25 revealed there was an order for lidocaine 4% patch apply topically to left elbow daily and remove at bedtime. Review of Resident #5's February 2025 eMAR to 02/28/25 revealed: -There was an entry for lidocaine 4% patch apply one patch topically to left elbow and remove at bedtime with a scheduled administration time of 8:00am and removal at 8:00pm. -There was documentation the lidocaine patch was applied 10 of 14 opportunities from 02/15/25 to 02/28/25. -There were 4 exceptions; the exception was the resident refused. Review of Resident #5's March 2025 eMAR revealed: -There was an entry for lidocaine 4% patch apply	D 367		

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D 367	Continued From page 280	D 367		

one patch topically to left elbow and remove at bedtime with a scheduled administration time of 8:00am and removal at 8:00pm.
-There was documentation the lidocaine patch was applied 16 of 31 opportunities from 03/01/25 to 03/31/25.
-There were 15 exceptions documented; there were 7 exceptions for the resident refused and 8 blanks on the eMAR.

Review of Resident #5's April 2025 eMAR from 04/01/25 to 04/24/25 revealed:
-There was an entry for lidocaine 4% patch apply one patch topically to left elbow and remove at bedtime with a scheduled administration time of 8:00am and removal at 8:00pm.
-There was documentation the lidocaine patch was applied 16 of 24 opportunities.
-There were 8 exceptions documented on the eMAR; the documentation was the resident refused.

Telephone interview with a representative from the facility's contracted pharmacy on 04/24/25 at 2:45pm revealed:
-The pharmacy had an order for lidocaine 4% patches apply 1 patch daily and remove in 12 hours dated 02/11/25.
-The pharmacy dispensed 30 lidocaine patches on 02/11/25 which would last for 30 days.
-The facility had not requested a refill.

Observation of Resident #5's medication on hand on 04/23/25 at 4:25pm revealed there were 20 of 30 lidocaine patches available for administration dispensed on 02/11/25.

Interview with a medication aide (MA) on 04/25/25 at 11:00am revealed:
-Resident #5 did not let her apply the lidocaine

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D 367	Continued From page 281	D 367		

patch.
-She would ask the Resident Care Coordinator (RCC) to apply the lidocaine patch because Resident #5 would let her.
-She did not know why there were so many lidocaine patches available for application.

Interview with a second MA on 04/28/25 at 5:20pm revealed:
-Resident #5 refused his lidocaine patch; he did not want it.
-She did not document the refusal on the eMAR.
-She was informed by a previous employee to document all refusals in the refusal book.
-She did not know where the refusal book was; she did not know if the refusal book was still being used.
-The Administrator told her last night to document refusals in the electronic progress notes, but she still did not document refusals on the eMAR.

Interview with a third MA on 04/29/25 at 9:53am revealed:
-Resident #5 had an order for lidocaine patch because he complained of pain in his left elbow.
-Resident #5 wore the patch a couple of times but had refused the patch since.
-When looking at the eMAR, it appeared the lidocaine patch was administered most days.
-The MAs were clicking on the eMAR as if the lidocaine patch was administered.
-The MAs needed to pay more attention to what they were doing.

Telephone interview with Resident #5's PCP on 04/25/25 at 3:00pm revealed:
-The lidocaine patches were ordered because Resident #5 complained of pain in his left elbow.
-She did not know he refused the lidocaine patches.

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D 367	Continued From page 282	D 367		

-If Resident #3 did not want the lidocaine patch, she was fine with it.

Interview with the RCC on 04/28/25 at 2:46pm revealed:
-Resident #5 was ordered the lidocaine patch because he was having pain in his left elbow.
-Resident #5 refused medications frequently, but Resident #5 would let her apply the lidocaine patch.
-Sometimes the MA would ask her to apply the lidocaine patch to Resident #5's left elbow.
-It appeared that the MAs were documenting they applied the lidocaine patch when they did not.
-The MAs should document on the eMAR correctly so the PCPs would have the correct information.

Interview with the Administrator on 04/29/25 at 4:53pm revealed:
-The lidocaine patches dispensed in February 2025 should be gone by now.
-The MAs should document correctly on the eMAR if Resident #5 was refusing the medication.

Attempted interview with Resident #5 on 04/23/25 was unsuccessful.

b. Review of Resident #5's current FL-2 dated 12/31/24 revealed there was an order for hydroxyzine 25mg (used to treat anxiety) three times daily PRN for anxiety.

Review of Resident #5's December 2024 electronic medication administration record (eMAR) from 12/14/24 to 12/31/24 revealed:
-There was an entry for hydroxyzine 25mg three times daily PRN for anxiety.
-There was no documentation that hydroxyzine

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 367	Continued From page 283	D 367		

was administered from 12/14/25 to 12/31/25.

Review of Resident #5's January 2025 eMAR revealed:
-There was an entry for hydroxyzine 25mg three times daily PRN for anxiety.
-There was no documentation that hydroxyzine was administered from 01/01/25 to 01/30/25.

Review of Resident #5's February 2025 eMAR revealed:
-There was an entry for hydroxyzine 25mg three times daily PRN for anxiety.
-There was no documentation that hydroxyzine was administered from 02/01/25 to 02/28/25.

Review of Resident #5's March 2025 eMAR revealed:
-There was an entry for hydroxyzine 25mg three times daily PRN for anxiety.
-There was no documentation that hydroxyzine was administered from 03/01/25 to 03/31/25.

Review of Resident #5's April 2025 eMAR from 04/01/25 to 04/24/25 revealed:
-There was an entry for hydroxyzine 25mg three times daily PRN for anxiety.
-There was no documentation that hydroxyzine was administered from 04/01/25 to 04/24/25.

Telephone interview with a representative from the facility's contracted pharmacy on 04/24/25 at 2:45pm revealed:
-The pharmacy had an order for hydroxyzine 25mg three times daily PRN for anxiety dated 12/13/24.
-The pharmacy dispensed 30 hydroxyzine 25mg tablets on 12/13/24.

Observation of Resident #5's medication on hand

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 367	Continued From page 284	D 367		

on 04/23/25 at 4:14pm revealed there were 17 of 30 hydroxyzine 25mg tablets available for administration dispensed on 12/13/24.

Telephone interview with Resident #5's PCP on 04/25/25 at 3:00pm revealed:
-Resident #5 had an order for hydroxyzine 25mg PRN for anxiety dated 12/13/24.
-She had access to the eMAR and could see if Resident #5 was utilizing the anti-anxiety medication.
-It appeared that Resident #5 was not being administered hydroxyzine 25mg since it was not documented on the eMAR.
-She did not know Resident #5 had been administered hydroxyzine since it was not documented on the eMAR.
-She would expect the MAs to document correctly on the eMAR so she would know how to adjust Resident #5's medications.

Attempted interview with Resident #5 on 04/23/25 was unsuccessful.

c. Review of Resident #3's current FL-2 dated 12/31/24 revealed there was an order for trazodone 100mg (used for insomnia) daily as needed (PRN) for sleep.

Review of Resident #5's December 2024 electronic medication administration record (eMAR) from 12/14/24 to 12/31/24 revealed:
-There was an entry for trazadone 100mg daily PRN for sleep.
-There was no documentation that trazadone was administered from 12/14/25 to 12/31/25.

Review of Resident #5's January 2025 eMAR revealed:
-There was an entry for trazadone 100mg daily

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 367	Continued From page 285 PRN for sleep. -There was no documentation that trazadone was administered from 01/01/25 to 01/30/25. Review of Resident #5's February 2025 eMAR revealed: -There was an entry for trazodone 100mg daily PRN for sleep. -There was no documentation that trazodone was administered from 02/01/25 to 02/28/25. Review of Resident #5's March 2025 eMAR revealed: -There was an entry for trazodone 100mg daily PRN for sleep. -There was no documentation that trazodone was administered from 03/01/25 to 03/31/25. Review of Resident #5's April 2025 eMAR from 04/01/25 to 04/24/25 revealed: -There was an entry for trazodone 100mg daily PRN for sleep. -There was no documentation that trazodone was administered from 04/01/25 to 04/24/25. Telephone interview with a representative from the facility's contracted pharmacy on 04/24/25 at 2:45pm revealed: -The pharmacy had an order for trazodone 100mg daily PRN for sleep dated 12/13/24. -The pharmacy dispensed 30 trazodone 100mg tablets dispensed on 12/13/24. Observation of Resident #5's medication on hand on 04/23/25 at 4:14pm revealed there were 22 of 30 trazodone 100mg tablets available for administration dispensed on 12/13/24. Telephone interview with Resident #5's PCP on 04/25/25 at 3:00pm revealed:	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 367	Continued From page 286 -Resident #5 had an order for trazodone 100mg daily PRN for sleep dated 12/13/24. -She had access to the eMAR and could see if Resident #5 was utilizing the sleep-aid. -It appeared that Resident #5 was not being administered trazodone since it was not documented on the eMAR. -She did not know Resident #5 had been administered trazodone since it was not documented on the eMAR. -She would expect the MAs to document correctly on the eMAR so she would know how to adjust Resident #5's medications. Interview with a MA on 04/25/25 at 11:00am revealed: -She administered PRN medications to Resident #5. -She would document the PRN medications on the eMAR. -She thought she documented on the eMAR when she administered Resident #5 his PRN medication. Interview with a second MA on 04/29/25 at 10:15am revealed: -She had administered PRN medications to Resident #5. -She documented PRN on the eMAR and would document the effectiveness of the PRN medication. -She did not realize she had not documented on the eMAR the PRNs she administered. Interview with a third MA on 04/28/25 at 5:20pm revealed: -She had administered PRN medications to Resident #5. -She did not document PRN medications that she administered to Resident #5 on the eMAR.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 367	Continued From page 287 -She was told last week to document the PRN medications in the electronic progress notes. -She did not know when other MAs administered PRN medications because there was no documentation of the eMAR of administration. -She never thought about the medication being given too close together since there was no documentation on the eMAR. Interview with the RCC on 04/28/25 at 2:46pm revealed: -The MAs should document all as needed medications on the eMAR when the medication was administered. -If the MA did not document on the eMAR when the PRN medication was administered, then another MA could administer the same medication too early. -The resident could have side effects from taking too much of a medication too close together, such as lethargy or confusion. -The MA should always document medication on the eMAR when it was administered. -The PCP had access to the eMAR and may check to see if the resident was using the PRN medications. Interview with the Administrator on 04/29/25 at 4:53pm revealed: -The MA should document all PRN medications administered on the eMAR and the effectiveness of the medication. -The on-coming MA would not know if a PRN had been administered and could administer the same PRN medication too soon. -She expected the MAs to document on the eMAR each time a PRN medication was administered.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 465	Continued From page 288	D 465		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the staff, who were trained in meeting the needs of the residents on the Special Care Unit (SCU), were present in sufficient number at all times and for 9 of 27 shifts sampled from 02/14/25 to 04/25/25. The findings are: Review of the facility's current license effective 01/01/25 revealed the facility was licensed for a capacity of 20 SCU beds. Review of the facility's undated Staff Scheduling Policy revealed: -The facility would maintain a posted staffing schedule that ensured qualified staff were available at all times to meet the care needs of residents. -Scheduling would be done fairly, predictably, and according to the staffing requirements outlined by the North Carolina Division of Health Service Regulation (DHSR).	D 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 465	Continued From page 289 Confidential interviews with staff revealed: -There were times when there was only a PCA and a MA in the SCU. -If the PCA or the MA took a break, there would only be one staff member in the SCU. Review of the census and punch cards for staff on 02/14/25 revealed: -There was a census of 18 residents, which required 18 aide hours on second shift. -There was a total of 5.5 aide hours provided on second shift leaving a shortage of 12.5 aide hours. Review of the census and punch cards for staff on 02/15/25 revealed: -There was a census of 18 residents, which required 14.6 aide hours on third shift. -There was a total of 0 aide hours provided on third shift leaving a shortage of 14.6 aide hours. Review of the census and punch cards for staff on 03/23/25 revealed: -There was a census of 18 residents, which required 14.6 aide hours on third shift. -There was a total of 9.25 aide hours provided on third shift leaving a shortage of 5.35 aide hours. Review of the census and punch cards for staff on 03/30/25 revealed: -There was a census of 18 residents, which required 18 aide hours on first shift. -There was a total of 14.5 aide hours provided on first shift leaving a shortage of 3.5 aide hours. Review of the census and punch cards for staff on 03/31/25 revealed: -There was a census of 18 residents, which required 18 aide hours on first and second shifts.	D 465		

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	HAL093010	A. BUILDING: _____ B. WING _____	R 04/29/2025

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D 465	Continued From page 290 -There was a total of 13 aide hours provided on first shift leaving a shortage of 5 aide hours. -There was a total of 11 aide hours provided on second shift leaving a shortage of 7 aide hours. Review of resident's incident/accident report dated 03/31/25 revealed: -He was noticed to be missing at 4:20pm. -He was found walking down the road in front of the facility by staff at 4:34pm. -The incident/accident happened on second shift. -Inservice provided and sign posted to not open the door. -The door company would be asked to assess the gate for a lock. Review of the census and punch cards for staff on 04/01/25 revealed: -There was a census of 19 residents, which required 19 aide hours on second shift. -There was a total of 12.5 aide hours provided on second shift leaving a shortage of 6.5 aide hours. Review of the census and punch cards for staff on 04/25/25 revealed: -There was a census of 18 residents, which required 18 aide hours on second shift and 14.6 aide hours on third shift. -There was a total of 12.75 aide hours provided on second shift leaving a shortage of 5.25 aide hours. -There was a total of 3.75 aide hours provided on third shift leaving a shortage of 10.85 aide hours. Observation of the SCU on 04/25/25 between 3:30pm-3:50pm revealed a PCA and a MA from an agency were the only staff members in the SCU. Interview with a PCA on 04/29/25 at 12:43pm	D 465		

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D 465	Continued From page 291 revealed: -She worked first shift and would stay over a few hours on second shift when needed. -The staff rotated from the SCU to the AL on the schedule. Interview with the Resident Care Coordinator (RCC) on 04/29/25 at 11:24pm revealed: -She helped complete the staff schedule. -There was always enough staff to cover shifts in the SCU. -When there were staff call-outs, she would contact facility staff to come in or a staffing agency to cover all shifts. -She would work to cover shifts when there were no staff available to work. Interview with the Administrator on 04/29/25 at 4:12pm revealed: -The facility used 3 shifts: 7:00am to 3:00pm, 3:00pm to 11:00pm, and 11:00pm to 7:00am, for aide shifts. -The RCC was responsible for completing the staff schedule. -She and the RCC were responsible to ensure the facility had enough staff based on the resident census each shift. -When shifts could not be covered by facility staff, she would contact the staffing agency to cover staffing in the facility. -The facility was offering the current staff bonuses to work extra hours. -She did not know the facility was short of aide hours on first shift on 03/30/25 and 03/31/25. -She did not know the facility was short of aide hours on second shift on 02/14/25, 03/31/25, 04/01/25, and 04/25/25. -She did not know the facility was short of aide hours on third shift on 02/15/25, 03/23/25, and 04/25/25.	D 465		

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D 465	Continued From page 292 Attempted telephone interview with a second PCA on 04/29/25 at 12:53pm was unsuccessful. Attempted telephone interview with a MA on 04/29/25 at 2:39pm was unsuccessful. Refer to Tag D04688, 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training _____ The facility failed to ensure enough staff were present in the SCU, which resulted in a lack of supervision of the residents. A resident was observed biting another resident when the SCU only had one staff member present; another resident was walking into a room that had a tripping hazard, and a third resident, who was in a wheelchair, was walking in his room unsupervised. This failure was detrimental to the health, safety, and welfare of residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/23/25 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 13, 2025.	D 465		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training:	D 468		

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D 468	Continued From page 293 (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews the facility failed to ensure that 7 of 8 sampled staff (B, C, D, E, F, G, and H) completed six hours of Special Care Unit (SCU) training within the first week of employment and 3 of 8 sampled staff (B, E, and F) completed 20 hours of SCU specific training within the first six months of employment. The findings are: 1. Review of Staff B's, medication aide (MA), personnel record revealed:	D 468		

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D 468	Continued From page 294 -She was hired on 07/22/24. -There was no documentation of six hours of SCU specific training within the first week of employment. -There was no documentation of 20 hours of SCU specific training within the first six months of employment. Attempted telephone interview with Staff B on 04/28/25 at 7:01pm was unsuccessful. Refer to the interview with the Licensed Health Professional Support (LHPS) nurse on 04/29/25 at 10:44am. Refer to the interview with the Special Care Unit Coordinator (SCC) on 04/29/25 at 12:04pm Refer to the interview with the Administrator on 04/29/25 at 4:12pm. 2. Review of Staff C's, medication aide (MA), personnel record revealed: -She was hired on 03/07/25. -There was no documentation of six hours of SCU specific training within the first week of employment. Telephone interview with Staff C on 04/28/25 at 7:08pm revealed: -She provided personal care for residents. -She administered medications for residents at the facility. -She did not recall if she received SCU training. Refer to the interview with the Licensed Health Professional Support (LHPS) nurse on 04/29/25 at 10:44am. Refer to the interview with the Special Care Unit	D 468		

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D 468	Continued From page 295 Coordinator (SCC) on 04/29/25 at 12:04pm Refer to the interview with the Administrator on 04/29/25 at 4:12pm. 3. Review of Staff D's, medication aide (MA), personnel record revealed: -She was hired on 01/09/25. -There was no documentation of six hours SCU specific training within the first week of employment. Attempted telephone interview with Staff D on 04/28/25 at 7:12pm was unsuccessful. Refer to the interview with the Licensed Health Professional Support (LHPS) nurse on 04/29/25 at 10:44am. Refer to the interview with the Special Care Unit Coordinator (SCC) on 04/29/25 at 12:04pm Refer to the interview with the Administrator on 04/29/25 at 4:12pm. 4. Review of Staff E's, personal care aide (PCA), personnel record revealed: -She was hired on 08/23/24. -There was no documentation of six hours of SCU specific training within the first week of employment. -There was no documentation of 20 hours of SCU specific training within the first six months of employment. Attempted telephone interview with Staff E on 04/28/25 at 7:18pm was unsuccessful. Refer to the interview with the Licensed Health Professional Support (LHPS) nurse on 04/29/25	D 468		

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D 468	Continued From page 296 at 10:44am. Refer to the interview with the Special Care Unit Coordinator (SCC) on 04/29/25 at 12:04pm Refer to the interview with the Administrator on 04/29/25 at 4:12pm. 5. Review of Staff F's, medication aide (MA), personnel record revealed: -She was hired on 07/18/22. -There was no documentation of six hours of SCU specific training within the first week of employment. -There was no documentation of 20 hours of SCU specific training within the first six months of employment. Telephone interview with Staff F on 04/28/25 at 7:41pm revealed: -She provided personal care for residents. -She administered medications for residents at the facility. -She did not recall if she received SCU training within the first week of employment. Refer to the interview with the Licensed Health Professional Support (LHPS) nurse on 04/29/25 at 10:44am. Refer to the interview with the Special Care Unit Coordinator (SCC) on 04/29/25 at 12:04pm Refer to the interview with the Administrator on 04/29/25 at 4:12pm. 6. Review of Staff G's, personal care aide (PCA), personnel record revealed: -She was hired on 03/15/25. -There was no documentation of six hours of	D 468		

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D 468	Continued From page 297 SCU specific training within the first week of employment. Telephone interview with Staff G on 04/28/25 at 8:43pm revealed: -She provided personal care for residents. -She did not recall if she received SCU training. Refer to the interview with the Licensed Health Professional Support (LHPS) nurse on 04/29/25 at 10:44am. Refer to the interview with the Special Care Unit Coordinator (SCC) on 04/29/25 at 12:04pm Refer to the interview with the Administrator on 04/29/25 at 4:12pm. 7. Review of Staff H's, medication aide (MA), personnel record revealed: -She was hired on 04/09/25. -There was no documentation of six hours of SCU specific training within the first week of employment. Attempted telephone interview with Staff H on 04/28/25 at 7:52pm was unsuccessful. Refer to the interview with the Licensed Health Professional Support (LHPS) nurse on 04/29/25 at 10:44am. Refer to the interview with the Special Care Unit Coordinator (SCC) on 04/29/25 at 12:04pm Refer to the interview with the Administrator on 04/29/25 at 4:12pm. _____ Interview with the LHPS nurse on 04/29/25 at 10:44am revealed:	D 468		

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D 468	Continued From page 298 -The Administrator was responsible for coordinating staff for SCU training. -She was responsible for providing training for SCU staff. -She provided 12 hours of SCU training within the first two days of when new staff were hired. -She was not aware of the requirement for 20 hours of training within six months of employment in addition to the six hours required in the first week of employment in the SCU. Interview with the Special Care Unit Coordinator (SCC) on 04/29/25 at 12:04pm revealed: -She could not recall how many hours of SCU training were required to work in the SCU. -The LHPS nurse was responsible for coordinating and training all staff working in the SCU. -She was not aware of the requirement for 20 hours of training within six months of employment in addition to the six hours required in the first week of employment in the SCU. Interview with the Administrator on 04/29/25 at 4:12pm revealed: -It was the responsibility of the LHPS nurse to ensure SCU staff completed the required training. -She was not aware of the requirement for 20 hours of training within six months of employment in addition to the six hours required in the first week of employment in the SCU. _____ The facility failed to ensure staff, who worked on the Special Care Unit, received orientation and training on the nature and needs of the residents, including personal care and supervision of the residents. This failure was detrimental to the health, safety, and welfare of residents and constitutes a Type B Violation. _____	D 468		

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D 468	Continued From page 299 The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/19/25 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 13, 2025.	D 468		