If continuation sheet 1 of 87

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1			(X3) DATE SURVEY COMPLETED	
AND PLAN (O CORNECTION	IDENTIFICATION NUMBER:	A. BUILDING:				
		HAL093010	B. WING		07/0) 8/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
ALPHA MA	AGNOLIA GARDEN		158 BUS E TON, NC 27589)			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
D 000	Initial Comments		D 000				
	County Department of a complaint investigation 06/09/25-06/11/25; 07 exit via telephone correcomplaint investigation	sure Section and the Warren f Social Services conducted tion on 06/06/25; 7/02/25 and 07/08/25 with an ofference on 07/08/25. The on was initiated on 05/13/25 of Department of Social					
D 080	Furnishings 10A NCAC 13F .0306 Furnishings (a) Adult care homes (6) have a supply ava times of bath soap, cl sheets, pillowcases, b covers such as a bed for each resident to u Notwithstanding the r	shall: ilable in the facility at all ean towels, washcloths, blankets, and additional spread, comforter, or quilt	An Initial audit of paper towers, soap, dispensers will be completed by Director/Administrator. Additional supplies will be ordered from manufacter by Administrator/Designess. Supplies will be installed as they arrive. An inservice will be completed with all staff regarding the proper use of dispensers. Ongoing weekly audits will be completed by Housekeeping Manager/Director/Administrator/Designee to ensure proper dispensing of supplies. The vendor representative will come quarterly to ensure dispensers are in place and working properly. Facility will maintain back up supply of dispensers.		7/25/2025		
		ns and interviews, the facility esidents had soap and paper					
	The findings are:						
	Care Unit (SCU) on 0 12:45pm-1:02pm reve						
	alth Service Regulation DIRECTOR'S_OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURI		TITLE		(X6) DATE	
	sey Check, K			Clinical Director	7/21/	2025	

Received on 08/04/25

Reviewed and Acknowledged

Janst Thornburg 08/14/25

6899 WJSU11

HAL093010 B. WING NAME OF PROVIDER OR SUPPLIER ALPHA MAGNOLIA GARDEN STREET ADDRESS, CITY, STATE, ZIP CODE 930 HWY 158 BUS E WARRENTON, NC 27589	AND PLAN OF
NAME OF PROVIDER OR SUPPLIER ALPHA MAGNOLIA GARDEN B. WING	
ALPHA MAGNOLIA GARDEN 930 HWY 158 BUS E WARRENTON, NC 27589	
ALPHA MAGNOLIA GARDEN WARRENTON, NC 27589	NAME OF PR
(YA) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	ALPHA MA
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	
D 080 Continued From page 1 -Room #1 did not have paper towels in the bathroom; three residents resided in the roomRoom #2 did not have paper towels in the bathroom; three residents resided in the roomRooms #4 and #5 shared a bathroom, and did not have paper towels; two residents resided in each roomRoom #6 did not have paper towels in the bathroom; two residents resided in the room. Observation of resident rooms in the SCU on 06/09/25 between 7:54am-8:30am revealed: -Room #1 did not have paper towels or hand towels in the bathroom; three residents resided in the roomRooms #4 and #5 shared a bathroom, and did not have paper towels or hand towels in the bathroom; two residents resided in each roomRooms #4 and #5 shared a bathroom, and did not have paper towels or hand towels in the bathroom; two residents resided in each roomRoom #6 did not have paper towels; two residents resided in the roomRooms #7 and #8 shared a bathroom, and did not have paper towels; two residents resided in the roomRooms #7 and #8 shared a bathroom, and did not have paper towels or hand towels in the bathroom; two residents resided in each room. Interview with a resident, who resided in room #4, on 06/10/25 at 7:54am revealed: -She ran out of paper towelsShe did not know who to ask for paper towels. Interview with a resident, who resided in room #6, on 06/10/25 at 7:58am revealed: -If there was a towel in the bathroom she dried her hands on it, but if not, she used her dressShe did not know who to ask for paper towels. Interview with a resident, who resided in room #7, on 06/09/25 at 8:12am revealed: -He did not always have paper towels in his bathroom.	

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 2 of 87

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
						С	
		HAL093010	B. WING		07	//08/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE			
		930 HWY	158 BUS E				
ALPHA M	AGNOLIA GARDEN	WARREN	NTON, NC 27589				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
D 080	Continued From page	÷ 2	D 080				
	ran outHe used his pants to washed them.	dry his hands when he about asking anyone for					
	on 06/09/25 at 8:14ar	e had paper towels in his re paper towels and					
	Based on observation residents who resided interviewable.	ns and interviews, the d in room #1 were not					
	Based on observatior residents who resided interviewable.	ns and interviews, the d in room #2 were not					
		ns and interviews, the two d in room #5 were not					
	Living (AL) on 06/06/2 revealed: -Room #5 did not have bathroom; three residence -Room #6 did not have bathroom; two residence -Room #9 did not have bathroom; two residence -Room #33 and #34 december -Room #35 did not have been supplied to the reverse -Room #35 did not have been supplied to the r	ident rooms in the Assisted 25 between 1:20pm-1:32pm are any paper towels in the lents resided in the room. The any paper towels in the not resided in the room. The any paper towels in the nots resided in the room. The any paper towels in the nots resided in the room. The any paper m; two residents resided in					
	Interview with a resid #34, on 06/09/25 at 1	ent, who resided in room :32pm revealed:					

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 3 of 87

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY PLETED
		HAL093010	B. WING		07	C 7 /08/2025
						706/2025
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
ALPHA M	AGNOLIA GARDEN		158 BUS E TON, NC 27589)		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CO	 DRRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	E APPROPRIATE	COMPLETE DATE
D 080	Continued From page	3	D 080			
	-He did not have any	paper towels in his room.				
		vels to dry his hands after				
	washing them with wa					
	-He dried his hands o	n his pants.				
	Interview with a residence on 06/09/25 at 8:15ar	ent, who resided in room #5,				
		pper towels in the bathroom.				
	-He went to the show	er room and washed his				
	hands.					
	Interview with a house	ekeeper on 06/11/25 at				
	7:57am revealed:					
		paper towels in the special				
	care unit (SCU) stora	en the next shipment of				
	paper towels were to					
	-No one had asked hi					
		l of paper towels in the				
	bathroom if a roll was	needed.				
		nd housekeeper on 06/11/25				
	at 8:07am revealed:					
	including paper towel	dered supplies every week,				
		ould be delivered tomorrow,				
	06/12/25.	,				
	Interview with the Hou	usekeeping Supervisor on				
	06/11/25 at 11:19am i	revealed:				
		hould check the bathrooms				
	each day and ensure towels.	each bathroom had paper				
		ed if there were no paper				
		ns and if more paper towels				
	needed to be ordered					
		dered the paper towels; she				
	did not know how ofte	en.				
	Interview with a repre	sentative for the facility's				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 4 of 87

Division of	of Health Service Regu	ilation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					l .	
			D WING		C	
		HAL093010	B. WING		07/0	8/2025
NAME OF PE	ROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, STAT	TE ZID CODE		
TVAIVIL OI	TOVIDER OR CO. 1 EIER			12, 211 0052		
ALPHA MA	AGNOLIA GARDEN		158 BUS E			
		WARREN	TON, NC 27589			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		COMPLETE DATE
TAG	KEGULATURT OR I	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	KIAIE	DAIL
	 			,		
D 080	Continued From page	e 4	D 080			
		mpany on 06/11/25 at				
	•	ere was an order for rolled				
	paper towels placed t	today, 06/11/25.				
	I					
	Interview with the SC	CU Coordinator (SCC) on				
	06/11/25 at 10:23am	revealed:				
	-Housekeeping staff r	made sure the bathrooms				
	were stocked with pa					
	-Housekeeping staff r	•				
		paper towels were in each				
	bathroom.	Applications from the second				
		ere were bathrooms that did				
	not have paper towels					
	Hornave haher rower	S.				
	2 Observation of resi	ident rooms in the Special				
		The state of the s				
		06/06/25 between 12:45pm				
	and 1:02pm revealed					
		npty soap dispenser; three				
	residents resided in the					
		ared a bathroom, and did not				
	T	bathroom; two residents				
	resided in each room					
		ve any soap in the bathroom;				
	two residents resided	I in the room.				
	I					
	Observation of reside	ent rooms in the SCU on				
	06/09/25 between 7:5	54am-8:30am revealed:				
	-Rooms #4 and #5, sl	hared a bathroom, and did				
	not have soap in the	bathroom; two residents				
	resided in each room	J.				
	-The first room on the	e left in the SCU did not have				
	soap in the bathroom	ı; two residents resided in				
	the room.					
	Interview with a resid	lent, who resided in room #4,				
	on 06/10/25 at 7:54ar					
	-She ran out of soap.					
	-She did not know wh					
	-Sile did flot kilow wil	io to ask for soap.			ļ	

Division of Health Service Regulation

Interview with a resident who resided in the first

STATE FORM 6899 WJSU11 If continuation sheet 5 of 87

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		HAL093010	B. WING		C 07/08/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ALPHA M	AGNOLIA GARDEN	930 HWY 1 WARRENT	58 BUS E ON, NC 27589			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 080	Continued From page	÷ 5	D 080			
	room on the left in the 8:21am revealed: -He did not have soap -He washed his hand					
	Based on observation residents who resided interviewable.					
	Based on observation residents who resided interviewable.	ns and interviews, the two d in room #5 were not				
	Living (AL) on 06/06/2 revealed: -Room #5 did not hav three residents resided-Room #9 did not hav two residents resided-Room #33 and #34 did	e any soap in the bathroom; in the room. lid not have any soap in the				
	Interview with a resident #34, on 06/06/25 at 1 -He did not have any					
	on 06/09/25 at 8:15ar -They did not have ar	ent, who resided in room #5, n revealed: ny soap in the bathroom. er room and washed his				
	7:57am revealed: -The soap dispensers	ekeeper on 06/11/25 at s were not the correct e bags of soap that were				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 6 of 87

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
7.1.12 1 2.1.1	5. GGT120.TGT.	.52	A. BUILDING: _				
		HAL093010	B. WING		I	C 08/2025	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	, ,,,	00,2020	
		930 HWY	158 BUS E	,			
ALPHA M	AGNOLIA GARDEN		TON, NC 27589				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C	OF CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	COMPLETE DATE	
D 080	Continued From page	e 6	D 080				
	sinks in the bathroom -The residents could bagsThere was not enough bathroomHe did not know whe was due to arrive. Interview with a seconat 8:07am revealed: -The Administrator or including soap.	s had been placed at the a, but not in the dispenser. pump the soap out of the gh soap to place in each en the next shipment of soap and housekeeper on 06/11/25 dered supplies every week, ensers had been ordered for					
	the residents' bathroo						
	_	hand dispensers were vey on 04/29/25.					
	ordered after the survey on 04/29/25. Interview with the Housekeeping Supervisor on 06/11/25 at 11:19am revealed: -The housekeepers should check the bathrooms each day and ensure each bathroom had soap. -She knew the containers of soap did not fit in the current soap dispensers for two weeks when she became the Housekeeping Supervisor. -She ordered the correct dispensers for the current containers of soap a week ago. -There were 20 soap dispensers delivered today, 06/11/25, and 15 more dispensers would be delivered tomorrow, 06/12/25. -There were 2 cases of containers of soap delivered today, 06/11/25, and she was expecting 7 more cases of soap tomorrow, 06/12/25. -The containers of soap were placed at the sink of the each bathroom until the dispensers arrived and were installed. -The residents could use the soap without it being in the dispenser; the pump was attached to the bag of soap.						

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 7 of 87

DIVISION	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			D MING		C
		HAL093010	B. WING		07/08/2025
NAME OF D	ROVIDER OR SUPPLIER	STDEET AS	DRESS, CITY, STA	TE ZID CODE	
NAIVIE OF FI	NOVIDER OR SUFFLIER		, ,	ie, zir cobe	
ΔΙ ΡΗΔ Μ	AGNOLIA GARDEN	930 HWY	158 BUS E		
ALI HA W	ACHOLIA CARDEN	WARREN	TON, NC 27589		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	(/
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE
				DEFICIENCY)	
D 000	0	- 7	D 080		
D 080	Continued From page	e /	D 000		
	Interview with a renre	sentative for the facility's			
	=	mpany on 06/11/25 at			
		ripariy or oo/ 11/25 at			
	12:25pm revealed:				
		dispensers ordered on			
	06/10/25 and delivered	ed to the facility today,			
	06/11/25.				
	-There was no order t	for soap, and no soap was			
	delivered today.				
	-There was no order s	scheduled for delivery			
	tomorrow, 06/11/25.				
	-The facility ordered 2	2 cases of soap in			
	-	h case contained 6 bags of			
	soap.				
	ooup.				
	Intonvious with the SC	U Coordinator (SCC) on			
	06/11/25 at 10:23am	` ,			
		nade sure the bathrooms			
	were stocked with so				
	-Housekeeping staff r				
		oap was in each bathroom.			
		ere were bathrooms that did			
	not have soap.				
	-She had boxes of so	ap in her office; because the			
	containers of soap wo	ould disappear when it was			
	stored in the supply s	torage room.			
	The facility failed to e	nsure residents had a			
		aper towels, at all times,			
		ents not having soap to bathe			
	_	ifter toileting and having to			
		their clothing. This failure			
		e health and safety of the			
	residents and constitu	utes a Type B Violation.			
		rovide an acceptable plan of			
	•	nce with G.S. 131D-34 on			
	06/11/25.				
			1		

Division of Health Service Regulation

THE CORRECTION DATE FOR THIS TYPE B

STATE FORM 6899 WJSU11 If continuation sheet 8 of 87

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING.		C	
		HAL093010	B. WING		07/08/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE		
ALPHA M	AGNOLIA GARDEN		158 BUS E			
	I		NTON, NC 2758			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 080	Continued From page	8	D 080			
	VIOLATION SHALL N 2025.	IOT EXCEED AUGUST 22,				
D 270	10A NCAC 13F .0901 Supervision 10A NCAC 13F .0901 Supervision (b) Staff shall provide	. ,	D 270	2 hour rounds will be completed on all res in AL and SCU. Staff completed 15 min cl for the first 72 hours following incident. St be inserviced on SCU and AL staffing and to be present on the floor the entire shift. Supervisors will complete ongoing/offgoin rounds with each other to report/monitor f	necks aff will I need g or any	
	accordance with each	resident's assessed needs, symptoms.		changes. Supervisors will audit 2 hour rou Monday-Friday.		
	This Rule is not met a TYPE A1 VIOLATION	-				
	reviews, the facility fa according to the resid of 5 sampled resident resident (#1) who resi (SCU) and was sexua resident and a resident Assisted Living (AL) v	ns, interviews, and record iled to provide supervision tents' assessed needs for 2 as (#1, #7) related to a ided in the special care unit ally assaulted by another and who resided in the who eloped from the facility as sitting on the ground (#7).				
	The findings are:					
	Review of Residen 05/24/24 revealed: -Diagnosis included d -She was ambulatory -The orientation section	•				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 9 of 87

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
70101270	or connection	BENTH IS ATION NO. II DE LA	A. BUILDING: _			
		HAL093010	B. WING		07/0)8/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ALPHA M	AGNOLIA GARDEN		158 BUS E FON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
D 270	Continued From page	= 9	D 270			
D 270	revealed: -The care plan was n Care Provider (PCP)There were no perfo for activities of daily li -She was oriented, bi -She was ambulatory Review of Resident # revealed: -Resident #7 had safe -There was documen checked on and was 12:00am to 12:00pm. Review of video foota surveillance camera of 07/08/25 revealed: -The surveillance camera of the facility facing the -The video footage w 4:23am; it was noted facilityThere was a stoop of had 5 steps leading to -At 4:23am, Resident on the stoop outside was holding the door	ot signed by the Primary rmance codes documented iving (ADL). ut forgetful. 7's ADL log dated 05/15/25 ety checks every 2 hours. tation that Resident #7 was safe every two hours from age from the facility's obtained on 07/02/25 and hera was on the outside of exit door of the dining room. as dated 05/15/25 at to be dark outside the	D 270			
	aroundAt 4:24am, she went door shut behind her	t back inside the facility; the but was slightly ajar.				
	-There was no video 4:24am-4:27am. -At 4:28am, Resident at the dining hall exit with her pants around -At 4:30am, Resident handle.	footage from #7 was observed standing door, outside of the facility,				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 10 of 87

DIVISION	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
			B. WING		С	
		HAL093010	B. WING		07/0	8/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE. ZIP CODE		
			, ,	,		
ALPHA MA	AGNOLIA GARDEN		158 BUS E			
		WARREN	ITON, NC 27589			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
TAG	REGOEMONT ON	190 BENTH THIS HIT GRAWATION	TAG	DEFICIENCY)	., ., .	
D 270	Continued From page	e 10	D 270			
	anddaa and aha fisiiat	- d 4b d who - b				
	ankles, and she twiste					
		#7 was knocking on the exit				
	door.	<i>u</i> =				
		#7 was knocking on the exit				
	_	ile standing on the stoop				
	with her pants down a					
	· ·	#7 was knocking on the exit				
	door.					
	-From 4:41am to 4:43					
	knocking on the exit of					
		#7 was knocking on a				
	window air conditioning	ng unit to the right of the exit				
	door.					
		#7 was hitting her hand				
	repeatedly on the woo	oden rail.				
	-At 4:46am, Resident	#7 was trying to pull her				
	pants up with one har	nd while holding onto the				
	wooden rail with her o	other hand.				
	-At 4:48am, Resident	#7's pants had not been				
	pulled up.					
	-At 5:19am, Resident	#7 was hitting the window				
	air conditioning unit w	vith her hand.				
	-At 5:28am, Resident	#7 was standing at the top				
	of the stoop; her pant	s were pulled up.				
	-It was noted to still b	e dark outside the facility.				
	-There was no video	footage from				
	8:14am-9:42am.					
	-At 9:42am, Resident	#7 was standing at the top				
	of the stoop.					
	-It was noted to be lig	ht outside the facility.				
	-At 9:55am, Resident	#7 was observed holding				
		the right side and slowly				
	moving down the step					
		nt #7 was observed standing				
	at the bottom of the s					
	handrail.	. •				
		nt #7 was observed on the				
		step; she was reaching				
	behind her, trying to h					
		dining room was opened,				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 11 of 87

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 930 HWY 158 BUS E WARRENTON, NC 27589 (X4) ID PREFIX TAG C 07/08/2025 O7/08/2025 O7/08/2025 O7/08/2025 O7/08/2025 O7/08/2025 O7/08/2025 O7/08/2025 O7/08/2025 O7/08/2025 O7/08/	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ALPHA MAGNOLIA GARDEN SUMMARY STATEMENT OF DEFICIENCIES WARRENTON, NC 27589 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 270 Continued From page 11 and a contracted construction worker was working on the door handle at the top of the steps and within sight of Resident #7. -There was no video footage from			A. BUILDING: _			
ALPHA MAGNOLIA GARDEN 930 HWY 158 BUS E WARRENTON, NC 27589 (X4) ID PREFIX TAG D 270 Continued From page 11 and a contracted construction worker was working on the door handle at the top of the steps and within sight of Resident #7There was no video footage from 930 HWY 158 BUS E WARRENTON, NC 27589 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTION SHOULD BE (EACH CO		HAL093010	B. WING			
ALPHA MAGNOLIA GARDEN WARRENTON, NC 27589 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 270 Continued From page 11 and a contracted construction worker was working on the door handle at the top of the steps and within sight of Resident #7. -There was no video footage from	NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
(X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) D 270 Continued From page 11 and a contracted construction worker was working on the door handle at the top of the steps and within sight of Resident #7. -There was no video footage from	AL PHA MAGNOLIA GAPDEN	930 HWY	158 BUS E			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE D 270 Continued From page 11 and a contracted construction worker was working on the door handle at the top of the steps and within sight of Resident #7. -There was no video footage from	ALFIIA MIAGNOLIA GARDEN	WARREN	TON, NC 27589			
and a contracted construction worker was working on the door handle at the top of the steps and within sight of Resident #7There was no video footage from	PREFIX (EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLETE	
working on the door handle at the top of the steps and within sight of Resident #7There was no video footage from	D 270 Continued From page	e 11	D 270			
-At 10:43am, Resident #7 was lying on the ground beside the bottom of the stepsThere was no video footage to show how Resident #7 ended up on the groundAt 10:59am, the contracted construction worker was working on the door handle, and Resident #7 was still lying on the ground at the bottom of the steps within sight of the doorAt 11:02am, the contracted construction worker continued to work on the door handleResident #7 appeared to try to sit up but was unable to and laid back downAt 11:07am, the contracted construction worker looked at Resident #7 and returned inside the facilityAt 11:14am, the Administrator, the Dietary Manager (DM), and the contracted construction worker exited the facility and observed Resident #7 lying on the groundAt 11:15am, the DM was standing over Resident #7, the Administrator and the contracted construction worker were standing at the top of the stoop, and the video footage endedThere was no video footage after 11:15am. Review of Resident #7's incident report dated 05/15/25 revealed: -The incident report was completed on 05/15/25 between 10:00am and 11:00amThe description of the incident was a contracted construction worker was working on the back door of the dining room and notified the DM that Resident #7 was outsideThe Administrator was immediately notified and	and a contracted con working on the door hand within sight of Re-There was no video 10:42am-10:43amAt 10:43am, Resider ground beside the boather was no video Resident #7 ended uport of the door of the dining roof Resident #7 was outs door of the dining roof Resident #7 was outs	struction worker was handle at the top of the steps esident #7. footage from Int #7 was lying on the attom of the steps. footage to show how p on the ground. tracted construction worker loor handle, and Resident #7 ground at the bottom of the he door. tracted construction worker the door handle. ed to try to sit up but was ck down. tracted construction worker 7 and returned inside the hinistrator, the Dietary he contracted construction illity and observed Resident d. was standing over Resident and the contracted vere standing at the top of deo footage ended. footage after 11:15am. Et's incident report dated was completed on 05/15/25 dd 11:00am. The incident was a contracted was working on the back of and notified the DM that side.	D 270			

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 12 of 87

Division of	of Health Service Regu	lation				
STATEMENT	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
			_		1 _	
			B WING		C	
		HAL093010	B. WING		07/0	8/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE		
TO WILL OF TH	TO VIDENCE ON GOLF EIEN		, ,			
ALPHA MA	AGNOLIA GARDEN		Y 158 BUS E			
		WARREN	NTON, NC 27589			
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX	`	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIAIE	DATE
				,		
D 270	Continued From page	e 12	D 270			
	to come to the back of the facility.					
	-The RCC, who was a	a Registered Nurse (RN)				
	found Resident #7 lyi	ng at the bottom of the			ļ	
	steps, with her upper	body on the last step and			ļ	
	her lower body on the				ļ	
		y clothed, but her clothes			ļ	
		because of the rain during			ļ	
	the night.	because of the fair during				
	-A physical assessme	ent was performed on				
	Resident #7 with no in	•			ļ	
	-Resident #7 denied I					
		sisted off the ground after			ļ	
	several attempts.					
		en inside and immediately			ļ	
		the personal care aide				
	(PCA).					
	-No apparent injuries	were noted to Resident #7				
	when a full body asse	essment was completed				
	during the shower.	·				
	-Resident #7 was dre	essed and walked to her				
	room with assistance	from the staff.			ļ	
	-Resident #7 asked to				ļ	
	-No further action req					
		to closely monitor Resident				
		laints related to the incident.				
	#1 for any new compi	laints related to the incident.				
	Pavious of Pasidont #	t7's progress potos royacled:				
		7's progress notes revealed:				
		nentation of the incident				
	dated 05/15/25.				ļ	
		nentation that the Mental				
	Health Provider (MHF) was notified of the				
	incident.					
		7's MHP triage note dated				
	05/15/25 revealed:					
	-The chief complaint	was Resident #7 continued				
	to refuse her medicat	ions.				
	-There was an order	to discontinue all scheduled				
	medications.				ľ	

Division of Health Service Regulation

-There was no documentation that the MHP was

STATE FORM 6899 WJSU11 If continuation sheet 13 of 87

DIVISION	of Fleatili Service Negu	lation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			D WING		C
		HAL093010	B. WING		07/08/2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		930 HWY	158 BUS E		
ALPHA M	AGNOLIA GARDEN		TON, NC 27589	1	
			1011, 110 2/303	T	
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD	()
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP	
		,		DEFICIENCY)	
D 070			D 070		
D 270	Continued From page	÷ 13	D 270		
	notified of Resident #	7 being found outside.			
		3			
	Interview with Reside	nt #7's roommate on			
	06/11/25 at 11:26am r	revealed:			
	-About 2 weeks ago,	she woke up at 4:00am and			
	Resident #7 was not i	n her bed.			
	-She stayed awake ur	ntil 5:00am, then she got up			
		ident #7 was not in her bed.			
	-She usually got up at	t 5:00am each morning and			
	Resident #7 would be				
	-Resident #7's bed wa	as not messed up like she			
	had slept in it that nig	ht.			
	-She did not know if F	Resident #7 was at breakfast			
	that morning.				
	Interview with a DCA	on 06/11/25 of 0:17om			
	revealed:	on 06/11/25 at 8:17am			
	 -She worked third shift morning of 05/15/25. 	ft and was working the			
	-She made rounds ev	ery two hours.			
	-Resident #7 was in h	er bed all night.			
	-At 6:00am, she starte	ed getting residents up and			
	dressed for breakfast.				
	-She got Resident #7	up and got her dressed for			
	breakfast which was s	served between			
	7:00am-7:15am.				
		esident #7's bed; first shift			
	made the beds.				
		sident #7 being outside.			
	_	up that morning, but she did			
		oom and did not come to			
	breakfast.				
		on 06/10/25 at 2:12pm			
	revealed:	0.0 am tha 0.1 tha			
	05/15/25.	A on the AL the morning of			
	-She was told Reside facility through the ba	nt #7 had gotten out of the ck door.			

Division of Health Service Regulation

-She did not see Resident #7 at breakfast.

STATE FORM 6899 WJSU11 If continuation sheet 14 of 87

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPL	=150
			D W****			
		HAL093010	B. WING		07/0	8/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
AL DUA M	ACNOLIA CARDEN	930 HWY 1	I58 BUS E			
ALPHA IVI	AGNOLIA GARDEN	WARRENT	ON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 270	noticed Resident #7's been slept in all night -She asked the Activit #7 was out of the faci another residentThe AD was checkin out of the facilityResident #7 was fou and the Administrator her back into the facili another residentThe DM, who was al Resident #7's shower -She was not soiled of -Her pants were dirty down on the ground. Interview with the DM revealed: -She was cleaning the	ds of the resident, she bed was made and had not ty Director (AD) if Resident lity while she assisted g to see if Resident #7 was and out back on the steps and the RCC were bringing ity while she finished helping so a PCA, assisted her with	D 270			
	was a lady lying out be stepsShe also worked as a Resident #7 to attempt the facilityShe got the Administ them Resident #7 was groundResident #7's pants could be seen through Resident #7's clother she appeared cold ar -She and a PCA show the shower Resident stool on her.	s were dirty and muddy and nd scared. vered Resident #7; during #7 was noted to have dried ner about what happened;				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 15 of 87

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL093010	B. WING	B. WING		07/08/2025	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
ALPHA M	AGNOLIA GARDEN		158 BUS E				
7 (= 1) ()		WARREN	TON, NC 27589				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPER DEFICIENCY)	BE	(X5) COMPLETE DATE	
D 270	Continued From page	e 15	D 270				
	completed or not.						
	11:06am revealed: -Resident #7 was alw saw herResident #7 did not sattempted to use a la application to assist was unsuccessfulThe staff did not tell the facility on 05/15/2 06/11/25, when she are a the staff should have #7 was found outside lt was unacceptable outside of the facility; injuredThe staff should be resident.	her Resident #7 got out of 5 until that morning, urrived at the facility. e notified her that Resident . that Resident #7 was she could have been making rounds at least every ot see Resident #7, they					
	(SCC) on 06/11/25 at -She heard a couple of there was an electron being outside the bac -She was not able to recording; she heard accessed the electron representative at the Services (DSS)She did not know ho outsideShe returned from pi 11:30am on 05/15/25	of days after the incident hic recording of Resident #7 k of the facility.					
	Interview with the RC	C on 06/10/25 at 2:46pm					

Division of Health Service Regulation

revealed:

STATE FORM 6899 WJSU11 If continuation sheet 16 of 87

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPLETED	'
					С	
		HAL093010	B. WING		07/08/20)25
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
41 5114 44		930 HWY	158 BUS E			
ALPHA MA	AGNOLIA GARDEN	WARREN ⁻	TON, NC 27589)		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		OMPLETE DATE
D 270	Continued From page	e 16	D 270			
D 270	-She saw the DM run office on 05/15/25The Administrator parto the back of the dinitive and the ground with the upon the bottom stepsShe was told a control saw her; he notified the AdministratorShe assessed her, and identifiedIt had rained the nighback and backside with the groundResident #7 was assint to the buildingThe PCA gave her and -Resident #7 was much clothing was not soiledThe PCA stated that in the shower, she had -Resident #7 did not solve and gotten out of the linterview with the Administrator.	ning to the Administrator's ged for all AL staff to report ing room. The saw Resident #7 lying on pper part of her back lying acted construction worker The DM who notified the and no injuries were and before and Resident #7's there wet from the moisture on asisted up and she ambulated shower and put her to bed. ddy and dirty, but her d with urine or stool. when she got Resident #7 d dry stool on her buttocks. smell as if she was soiled. any other time Resident #7	D 270			
	4:07pm revealed:	truction worker came and				
		and told them there was a				
	resident outside in the					
	-The DM came out als	-				
		he bottom of the steps, lying				
	with her back on the					
		t #7's clothing was clean;				
		ack side of her clothing.				
		e side of her pants; there				
		incontinence and no odor.				
	-There was feces bes					
	Resident #1 had a bo	wel movement.				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 17 of 87

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	COMP		(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		HAL093010	B. WING		C 07/08/2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
ALPHA MA	AGNOLIA GARDEN	930 HWY	158 BUS E		
	TOTOLIN COMEDITY	WARREN	TON, NC 27589		,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 270	Continued From page	e 17	D 270		
	injuries notedThe PCA showered I -Resident #7 did not v facility; she stated sur -It was between 9:30a Resident #7 was brou- She did not know ho been outsideThe contracted cons on the alarm on the b propped openShe did not know Re breakfastIf she was not at bre stopped and looked for- She did not know the	want to come back into the n, sun. am to 10:00am when ught into the facility. w long Resident #7 had truction worker was working ack door; he left the door esident #7 was not at akfast, the staff should have			
	Telephone interview with the Owner on 06/11/25 at 3:44pm revealed: -She was informed Resident #7 was found outside of the facility on 05/15/25A contracted construction worker was working on the alarms for the back door of the dining room and left the back door openResident #7 went outside when the door was left openThe contracted construction worker saw Resident #7 outside and reported it to the staffShe had not seen an electronic recording of Resident #7 being outsideShe did not know an electronic recording of Resident #7 being outside existedShe did not know the electronic recording showed Resident #7 outside from 4:28am to 10:45am on 05/15/25She was concerned that something could happen to Resident #7; she could get hurt.				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 18 of 87

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN (OF GURRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED
		HAL093010	B. WING		l l	C / 08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
ALPHA M	AGNOLIA GARDEN		' 158 BUS E NTON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 270	Continued From page	e 18	D 270			
	Attempted interview v construction worker of unsuccessful.	with the contracted on 06/09/25 at 4:47pm was				
		ns, interviews, and record nined Resident #7 was not				
	2. Review of the cens in the SCU on 06/03/	sus log revealed the census 25 was 15.				
	Review of Resident #1's current FL-2 dated 02/11/25 revealed: -Diagnoses included dementia, major neurocognitive disorder, hyperlipidemia, and pre-diabetesShe was constantly disorientedShe was ambulatory and wandered.					
	revealed: -Her diagnoses includisorder, insomnia, sedementiaShe was ambulatory -She was always disc	<u>.</u>				
	television roomThere were no staff i -There was a persona hallwayThere was a second -Resident #1 was in a					

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 19 of 87

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL093010	B. WING		C 07/08/2025	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
лі рыл м.	AGNOLIA GARDEN	930 HWY	158 BUS E			
ALFHA WI	AGNOLIA GARDEN	WARREN	TON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 270	Continued From page	e 19	D 270			
D 270	adult incontinence bri ankles. -The PCA was notified to assist the residentThere were no other the SCUAt 12:39pm, the second SCU. Observation of the SC 1:04pm-1:08pm revealing the second SCU. Observation of the SC 1:04pm-1:08pm revealing the second SCU. Observation of the SC 1:04pm-1:08pm revealing the second SCU. Observation of the SC 1:04pm-1:08pm revealing the second SCU. A housekeeper was second Resident #1 picked upon the second	d, and she entered the room staff members present in ond PCA returned to the CU on 06/06/25 from aled: in the SCU. mopping the floors. lking in the hallway. up the wet floor sign and wn the hallway. ot to the exit door of the e sign, and it made a loud of be seen from the e the PCA was supervising ne down the hallway to oise made when Resident ed to walk in the hallway, her residents' rooms. and PCA returned to the SCU. ed's incident/accident report led: was completed on 06/03/25 ee incident was a male of Resident #1 with their ey need to be sent out for	D 270			
	treatment, was check -There was no signate completed this report	ure of the staff who				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 20 of 87

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE COMP	SURVEY LETED	
						С
		HAL093010	B. WING			08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE	, ZIP CODE		
ΔΙ ΡΗΔ Μ	AGNOLIA GARDEN	930 HWY	158 BUS E			
ALITIA	AONOLIA GARBER	WARREN	TON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AIDEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 270	Continued From page	20	D 270			
	-The Administrator sig	gned the report on 06/04/25.				
	06/03/25 revealed: -The Administrator restaff member that a President having sex we-The residents were substantially administrator told the the residents. Review of the service	eparated, and the PCA to keep a close eye on note sheet from Resident				
	at 9:18pm revealed: -The on-call guardian telephone call from th -The Administrator pro Resident #1 was loca male resident and wa	e facility's Administrator. ovided information that ted in the bedroom of a				
	consensual; there wa or force by the male r was not traumatized the The Administrator information of the Administrator information of the Administrator was and she stated that she or force or force was a force of the Administrator was and she stated that she or force or fo	ormed the guardian that rected to her bedroom staff would perform bed stees. anted to inform the guardian,				
	revealed: -She worked the ever 06/03/25She was the only PC incident between Res	on 06/09/25 at 3:16pm ning shift in the SCU on A in the SCU when the ident #1 and a male other PCA and the MA had				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 21 of 87

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		'	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		HAL093010	B. WING		07/08/2025	
NAME OF F	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ITE, ZIP CODE		
ALPHA M	AGNOLIA GARDEN		158 BUS E			
	T		TON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
D 270	Continued From page	21	D 270			
D 270	left the floorResident #1 was in the when she went into a provide incontinenceShe heard a female stop; she recognizedShe opened the male and saw Resident #1 chair and the male reflected with the male reflected with the second with the male resident had penetrated and the male resident had penetrated with the male resident replied no be sexShe told the male resident replied no be sexShe told the male resident replied no be sexShe told the male resident #1 was hisThe male resident st #1 and she removed resident #1 was hisThe male resident st #1 and she removed resident's roomShe called for the me AL side to come to the SCU MA what happed the AdministratorThe Administrator careport about the incidence of the SCU MA say no, no, stop, stopShe told the Administration with the MA revealed: -She was the MA on so 06/03/25She could hear loudShe was administering when the SCU PCA could hear loud.	the television (TV) room, nother resident's room to care. voice yelling no, no, stop, the voice as Resident #1. e resident's bedroom door bent over the back of a sident was behind Resident as were down, and the male ed Resident #1. sident to stop and the male ecause they were having sident that Resident #1 was replied it did not matter; repped away from Resident Resident #1 from the male edication aide (MA) on the escu, the AL MA told the ned, and the SCU MA called and asked her to write a lent and what she saw. A that she heard Resident #1. It trator that the male resident esident #1. It to no 06/10/25 at 5:11pm second shift in the AL on noise coming from the SCU. It am the only one back	D 2/0			

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 22 of 87

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
			7.1. 56.125.1.16.			0
		HAL093010	B. WING			C 7/ 08/2025
		11AL093010			1 07	100/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
ΔΙ ΡΗΔ Μ	AGNOLIA GARDEN	930 HWY	158 BUS E			
7(2) 117(111	7.01.021.7.07.11.021.1	WARREN	ITON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
D 270	Continued From page	e 22	D 270			
D 270	-She asked the SCU in the SCU and the P was gone for 45 minuThe PCA had separa -The male resident w wrong with himHe was aggressive at to grab the staffThe staff tried to kee he came out the door aggressively, pinning hit her in the faceThere was supposed SCU, but the MA and floor, leaving only one leaving only one statement of the staff ran out to the AL to go when she got to the in his room; she did not he male resider ran out to the AL to go when she got to the in his room; she did not he male resident of the staff rand another PC his door, to try and keen the staff rand them, pinned bedroom door and put happened around 10:	PCA why she was by herself CA told her another PCA ates. ated them. as "off"; something seemed and he looked like he wanted and he looked like he wanted and charged at the PCA at the up against the door and at to be three people in the the other PCA had left the ePCA in the SCU. Ind PCA on 06/10/25 at the break when the PCA, who ent assaulting Resident #1, et someone. SCU, the male resident was not see Resident #1. It the male resident #1. It the male resident was not see Resident #1. It the male resident was not see Resident #1. It the male resident the proom. A went to his room to close the phim calm. In the other PCA up against his anched her in the face; this coopm. after the PCA was hit in the	D 270			
	happened, he said ye -When Emergency M arrived, they question did not remember wh	eah, he [expletive] her. edical Services (EMS) ned the male resident and he				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 23 of 87

, , ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BUILDING: _			
		HAL093010	B. WING		07/08	3/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ALPHA M	AGNOLIA GARDEN	930 HWY 1 WARRENT	58 BUS E ON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 270	Continued From page	e 23	D 270			
	happened or asked h	er to write a statement.				
	2:53pm and 4:16pm r -She was working in the incident occurred the male resident, but the time the incident of the time the incident of the time the incident of the something out of her and the properties of the	the SCU on 06/03/25 when between Resident #1 and t she was not in the SCU at occurred. Itside of the facility to get car. Itside of the facility to get car. Itside and told her she was curred. Itside and told her residents' we to let her walk; we could more than a 15-minute she the incident occurred. Itside resident, who did not was on top of Resident #1. Itside resident #1 had clothes on curred in the she she started in the she she she started in the she she she started in the she she she she she she she she she s				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 24 of 87

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		HAL093010	B. WING		C 07/08/2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
ALPHA M	AGNOLIA GARDEN	930 HWY 1 WARRENT	58 BUS E ON, NC 27589	•	
0/10/15	STIMMADV ST.	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	N OVE
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 270	Continued From page	e 24	D 270		
	she had heard from the guardian said Reside behavior and they did against the male residence. Resident #1 was not able to decide to have a large of the end of the en	nt #1 had a history of this I not want to press charges dent. oriented and would not be e sex. the facility for another rsonnel were told about the t #1 and that was how law lived. MA on 06/09/25 at 10:39am evening of the incident and a male resident. or that the male resident had #1 in his room one time prior 03/25. assistance with everything. aware of her surroundings. sident #1 was capable of			
	on 06/11/25 at 10:53a -The facility did not no				
	-Last night she was p today, when she read Resident #1's notes. -The SCC told her tha	at morning that Resident #1			
	-That was not good; t monitoring the reside memory care unit.	nts because it was a			

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 25 of 87

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL093010	B. WING		07/08/2025	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
AL DUA M	AGNOLIA GARDEN	930 HWY 1	58 BUS E			
ALPHA WI	AGNOLIA GARDEN	WARRENT	ON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE C	(X5) COMPLETE DATE
D 270	Continued From page	25	D 270			
D 270	redirectingResident #1's cognitive declined; she could not herselfResident #1 should be minutes or be within a timesThere was one previous where Resident #1 we room with her pants of penetrationShe told staff to mon because of her cognitive. Telephone interview wat 8:46am revealed: -He was the guardian call was received from regarding Resident #1 residentHe was assured the and was not told it wat her asked the Adminited her and was not told it wat her asked to gather and following an instance assault) and the AdmiconsensualHe knew the resident Her was not told the February received one regarding this incident regarding this incident.	on was not great and it had on make decisions for the checked on every 15 an eye's view of staff at all cous incident months ago, as found in a male resident's fown but there was no litor Resident #1 closely live decline. In a guardian on 06/09/25 on call on 06/03/25 when a finite the Administrator of the Administrator with a male of the Administrator of the Admi	D 270			
	-Unless precautions v					

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 26 of 87

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPL			
			A. BUILDING: _			0
		HAL093010	B. WING		l l	C 08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
AI PHA M	AGNOLIA GARDEN	930 HWY	158 BUS E			
ALITIA	AGNOLIA GARBER	WARREN	TON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 270	Continued From page	e 26	D 270			
	Telephone interview of Coordinator (SCC) or revealed: -She received a telep Administrator about the involving Resident #1 -She wanted to know guardian was and the would call the guardiation was at the would call the guardiation of the wast to the start male resident on 06/01 Interview with the Administrator of the word of the series with the Administrator of the wast to the start male resident on 06/03 saying that a male resident #1 and their she did not ask the start incidentShe instructed the M residents, do an incident of the series of the word of the series of the should be two times; three staff were should be off the SCU. Based on observation reviews it was determinterviewable.	with the Special Care in 06/09/25 at 6:41pm shone call from the the incident on 06/03/25 and a male resident. who Resident #1's legal to Administrator said she an and handle it. 15 minutes checks on the 04/25. ministrator on 06/09/25 at the shone call between 6:00pm to 7/25 from the MA on the SCU sident was on top of the clothes were pulled down. MA any questions about the shall be scheduled and she would redian for Resident was on the staff on the SCU at all the scheduled and only one down the scheduled and only one down the scheduled and record the specific part of the scheduled and record the specific part of the scheduled and record the scheduled and rec				
	provided according to needs, for a resident the back door of the f	nsure supervision was the resident's assessed (#7) who wandered out of facility and was outside from 14am. The resident was				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 27 of 87

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE COMPLETED		
		HAL093010	B. WING		C 07/08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE	
ALPHA M	AGNOLIA GARDEN		/ 158 BUS E NTON, NC 2758	9	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLET
D 270	feces, mud, and dirt. in serious neglect to a constitutes a Type A1 The facility provided a protection in accorda 06/30/25. THE CORRECTION VIOLATION SHALL N 2025.	r clothing soiled with urine, The facility's failure resulted the resident, which	D 270	All facility policies/procedures are to be for by all staff. An inservice/training will by	e held
	10A NCAC 13F .090° Supervision (c) Staff shall respon an accident or incider provide care and interfacility's policies and This Rule is not met Based on observation reviews, the facility faresponse and interve with the facility's policies.	as evidenced by: as evidenced by: as, interviews, and record ailed to ensure immediate antion by staff in accordance sies and procedures for 1 of #1) who resided in the		with all staff to review all policies. Admin Director/Designee will complete the training the state of the training that the state of t	

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 28 of 87

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
			B. WING		С
		HAL093010	B. WING		07/08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
ALPHA M	AGNOLIA GARDEN		158 BUS E		
			TON, NC 27589		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 271	Continued From page	e 28	D 271		
	The findings are:				
	Review of the facility'	s undated Sexual Assault			
	Prevention and Resp	onse Policy revealed:			
	-Sexual assault was o	•			
	including unwanted to	al contact or behavior,			
		d as a clear, voluntary, and			
		to participate in sexual			
	activity.				
	-Residents with cogni able to legally conser	itive impairments may not be			
	0 ,	าเ. า and privacy protocols must			
	be followed.	rana privady protodolo made			
	-The staff must monit residents.	or interactions between			
		nfirmed incident must be			
	Department of Social	to the Administrator and the Services (DSS) as required			
	by law.	designee would coordinate			
		and DSS to conduct a			
		pe provided with medical			
	care, emotional suppo during and after the in	ort, and a safe environment nvestigation.			
	Review of Resident # 02/11/25 revealed:	1's current FL-2 dated			
	-Diagnoses included	dementia, major			
	neurocognitive disord	ler, hyperlipidemia, and			
	pre-diabetes.				
	-She was constantly of -She was ambulatory				
	Review of Resident #	1's care plan dated 02/04/25			
	-Diagnoses included	maior neurocognitive			
	disorder, insomnia, se				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 29 of 87

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:		(X3) DATE SURVEY COMPLETED	
						С
		HAL093010	B. WING		07	//08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	ODRESS, CITY, STATE	E, ZIP CODE		
ΔΙ ΡΗΔ Μ	AGNOLIA GARDEN	930 HWY	158 BUS E			
7121117111	71011021171 071110211	WARREN	ITON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
D 271	directed. Review of Resident # 06/03/25 revealed: -The incident report v at 6:30pmThe description of the resident was on top of clothes offThe question of did to treatment, was checkedThere was no signate completed this reportedThe Administrator signated for the Administrator restaff member that a penal walked in on a measure of the residentsThe Administrator told the the residentsThe Administrator carguardian and informed communicated to here-The guardian informed.	priented. Interpretation of the staff who is greated a call from the facility personal care aide (PCA) aller esident #1's on-call ad them of what was	D 271			
	#1's court-appointed 06/03/25 at 9:18pm re -The on-call guardian					

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 30 of 87

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL093010	B. WING	B. WING		8/2025
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE. ZIP CODE	1 0170	0.1010
		930 HWY 1		· - , · · · · · · · · · · · · · · · · · ·		
ALPHA M	AGNOLIA GARDEN	WARRENTO	ON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 271	Resident #1 was loca male resident and wa with the male resident -She indicated the enconsensual; there was or force by the male rewas not traumatized but -The Administrator was and she stated that shincident report and wo #1's PCP. Review of the telement 11:08pm on 06/03/25 -The complaint was Remale resident's room -The guardian was concerned asking if Resident #1 -There was no resport AdministratorThe MHP responded Resident #1 to the enthe guardian's refusal -Orders received for lahuman immunodeficie hepatitis B and C, chl. Telephone interview wo 06/06/25 at 2:50pm re-She was not notified Resident #1 and the re-She was concerned to the consequence of the conseque	ovided information that ted in the bedroom of a sengaging in sexual activity it. counter appeared to be so no indication of coercion esident and Resident #1 by the encounter. Intended to inform the guardian, ne would complete an ould also notify Resident with the example of the incident want of the incident was the Administrator. Intended to inform the guardian ould also notify Resident was found in a shaving sex. Intacted and did not want was the Administrator. Intended to inform the want was the Administrator. Intended to inform the was found in a shaving sex. Intacted and did not want was the Administrator. Intended to inform the was documented from the was alert and oriented. Intended to inform the was noted. Intended to information the want was the Administrator. Intended to inform the guardian, and oriented to information the want was the Administrator. Intended to inform the guardian, and oriented at the want was the Administrator. Intended to inform the guardian, and oriented at the want was the Administrator. Intended to inform the guardian, and want was the Administrator. Intended to inform the guardian, and want was the Administrator. Intended to inform the guardian, and want was the Administrator. Intended to inform the guardian, and want was the Administrator. Intended to inform the guardian, and want was the Administrator. Intended to inform the guardian, and want was the Administrator. Intended to inform the guardian, and want was the Administrator. Intended to inform the guardian, and want was the Administrator. Intended to inform the guardian, and want was the Administrator. Intended to inform the guardian, and want was the Administrato	D 271	DEFICIENCY)		
	a medical professional -The resident should l					

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 31 of 87

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPL	EIED
		HAL093010	B. WING		07/0	; 8/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		930 HWY 1	58 BUS E			
ALPHA M	AGNOLIA GARDEN	WARRENT	ON, NC 27589	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 271	Continued From page	e 31	D 271			
D 271	Interview with Reside 9:38am revealed: -She was informed by morning, 06/10/25, of Resident #1 and a mathematical and a mathemat	of the Administrator that if the incident between ale resident. The incident between ale resident and the on-call at Resident #1 sent to the ED. The her the impression it was a d by the Administrator that and no, no, stop, stop during the esident #1 had said no, she the incident and had the incident and had the incident are peen granted for Resident sident did not have the isions on her own. The incident are the incident are seven as sexual assault kit the forensic department. Int #1's MHP on 06/11/25 at the otify her regarding the 25 between Resident #1 and the incident is. For (SCC) told her that the incident is and incident the incident is and incident in the read about the incident is and incident in the incident is and incident in the incident in the incident is and incident in the incident in the incident is and incident in the incident in th	D 271			
	listening to the guardi Resident #1 to the ED	an and not sending				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 32 of 87

PRINTED: 07/08/2025 FORM APPROVED

Division of Health Service Regulation

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SI COMPLE	
			A. BOILDING.			
		HAL093010	B. WING		07/0	8/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ATE, ZIP CODE		
ΔΙ ΡΗΔ Μ	AGNOLIA GARDEN	930 HWY	158 BUS E			
ALF HA IVI	AGNOLIA GARDEN	WARREN	TON, NC 27589	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 271	Continued From page	e 32	D 271			
	called 911She did not know wh sexual abuse.	at the facility's policy was for				
D 273	to meet the routine ar of residents. This Rule is not met TYPE A1 VIOLATION Based on observation reviews, the facility fa follow-up to meet the sampled residents (# a resident who was s sent to the hospital in (#1), two residents wl jagged and were not #8), and a resident w with her whereabouts	2 Health Care assure referral and follow-up and acute health care needs as evidenced by:	D 273	Provider has been made aware of all incic Staff are being inservices on using Telem notify provider/on call around the clock. Wimplement a communication log of all noting RCC/Director/Administrator/Designee will logs and bring them to daily stand up med (M-F) and Manager on Duty will notify on weekends. A podiatry audit will be compleall residents. Any residents not currently of service will be offered services.	edic to /e will fications. review etings	8/5/2025
	The findings are:					
	Prevention and Resp -Sexual assault was of non-consensual sexus including unwanted to -Consent was defined informed agreement to activity.	al contact or behavior,				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 33 of 87

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	IED
		HAL093010	B. WING		07/08	/2025
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
ALPHA M	AGNOLIA GARDEN	930 HWY 1 WARRENT	58 BUS E ON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	be followed. -The staff must monitoresidents. -Any suspected or correported immediately Department of Social by law. -The Administrator or with law enforcement thorough investigation. -The resident will be premotional support, and after the investigation. Review of Resident # 02/11/25 revealed: -Diagnoses included oneurocognitive disord pre-diabetes. -She was constantly or she was ambulatory. Review of Resident # revealed: -Diagnoses included of disorder, insomnia, sedementia. -She was ambulatory. She was ambulatory. -She was ambulatory.	and privacy protocols must for interactions between suffirmed incident must be to the Administrator and the Services (DSS) as required and DSS to conduct a m. provided with medical care, and a safe environment during ation. It is current FL-2 dated dementia, major der, hyperlipidemia, and disoriented. If and wandered. It is care plan dated 02/04/25 major neurocognitive eizure disorder, and to be an ememory loss; she had to be	D 273	DEPICIENCI)		
	resident was on top o	of Resident #1 with their				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 34 of 87

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY PLETED	
			7. BOILDING			С
		HAL093010	B. WING	<u>-</u>	07	/08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	ODRESS, CITY, STATE	E, ZIP CODE		
41 5114 44		930 HWY	158 BUS E			
ALPHA M	AGNOLIA GARDEN	WARREN	ITON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 273	clothes off. -The question of did tout for treatment, was -There was no signat completed this report -The Administrator signated the service of Resident # 06/03/25 revealed: -The Administrator restaff member that a phad walked in on a mage of the service #1's court-appointed of 06/03/25 at 9:18pm results of the service of the on-call guardian telephone call from the service of	the resident need to be sent is checked no. The staff who have a compared the report on 06/04/25. The staff who have a call from a facility derived having sex with the separated, and the fact the PCA to keep a close dealled Resident #1's on-called them of what was from the staff. The did not want the resident by department (ED) because lot in other facilities and he happen again. The determinant of the Administrator to care provider (PCP) and keep as contacted by telemed, and for labs to be drawn.	D 273	DEFICIENC		
	male resident and wa activity. -She indicated the en	ated in the bedroom of a as engaging in sexual accounter appeared to be as no indication of coercion				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 35 of 87

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
7.1.5 / 2.1.7 6.7 66.11.26.1.6.1		A. BUILDING: _	A. BUILDING:		
	HAL093010	B. WING		07/0	8/2025
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
ALPHA MAGNOLIA GARDEN	930 HWY WARREN	158 BUS E TON, NC 27589			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
was not traumatized b -The Administrator info Resident #1 was redir without incident and st checks every 15 minut -The Administrator wa and she stated that sh incident report and wo PCP. Review of the telemed 11:08pm on 06/03/25 -The complaint was Re male resident's room h residentThe guardian was con Resident #1 sent outThe reporting person -The mental health pro with the question if Re orientedThere was no respon AdministratorThe MHP responded Resident #1 to the ED notedOrders were received including human immus syphilis, hepatitis B an gonorrhea. Review of the local law report dated 06/03/25 -The law enforcement at the facility for a mal care unit (SCU) with a was holding people do -Emergency Medical S	esident and Resident #1 by the encounter. by the facilian that ected to her bedroom taff would perform bed tes. Intend to inform the guardian, the would complete an every point of the facility's dicine thread started at revealed: esident #1 was found in a chaving sex with the male Intacted and did not want was the Administrator. by ider (MHP) responded esident #1 was alert and se documented from the and recommended sending by the guardian's refusal was at for laboratory testing, unodeficiency virus (HIV), and C, chlamydia, and wenforcement investigation at 9:53pm revealed: officer responded to a call the resident in the special and altered mental status who by and punching them.	D 273			

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 36 of 87

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					С	
		HAL093010	B. WING		07/08/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
ALPHA M	AGNOLIA GARDEN	930 HWY				
		WARRENT	TON, NC 27589)		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET	ΓE
D 273	who stated the male Resident #1 earlier in 6:00pm. -The PCA stated she about the sexual assilaw enforcement. -The PCA stated she resident and saw the down; he had pulled and was penetrating. -The PCA stated Resident PCA advised the not supposed to be diresident responded in thought. -The law enforcement interview Resident #1. -The law enforcement a few basic questions hey and no. -The staff member salike this and did not such advised the APS. -The law enforcement and advised the APS.	t officer spoke with a PCA resident sexually assaulted the evening, around contacted the Administrator ault and was told not to call went to check on the male male resident with his pants Resident #1's pants down Resident #1. ident #1 was saying stop. It makes the male resident that he was oing that and the male redid not care what she tofficer attempted to the with a staff member. It officer asked Resident #1 would say wild Resident #1 was always ay much. It officer contacted the reservices (APS) worker worker of the situation. It officer was informed by the as a law enforcement issue,	D 273			
	Review of the local la	nw enforcement officer's ation report dated 06/03/25 at				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 37 of 87

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7. BOILDING.		C	
		HAL093010	B. WING			3/2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ALPHA MA	AGNOLIA GARDEN	930 HWY 1 WARRENT	58 BUS E ON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	at the facility on the e -The PCA stated that no, no, no, from inside -The PCA entered the observed Resident #* pants down and the n with herThe PCA stated she what they were doing -The PCA stated she was not what that was responded he did not -The PCA assisted wi pants pulled up and w -When she returned t the male resident was male resident tell ano was next [expletive]The on-call law enfor notifiedHe was informed by officer that he had no of Social Services (DS -The local law enforce attempted to speak to unable to make any s	CA who witnessed the rape vening of 06/03/25. she heard someone saying e a male resident's room. It has been a male resident's room and a bent over the bed with her male resident engaged in sex asked the male resident having sex. and he replied having sex. and the male resident that is, and the male resident care what she thought. The getting Resident #1's walked her back to her room. To the television room, where is sitting, she overheard the ther female resident she rement investigator was the local law enforcement tified the on-call Department SS) APS worker.	D 273			
	EMS personnel on so the Administrator who Resident #1's PCP ar	ene had made contact with made contact with nd was advised not to ent due to Resident #1's				
	Telephone interview v enforcement officer o revealed:	vith the responding local law n 06/11/25 at 5:35pm lated to a resident having at the facility.				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 38 of 87

, , ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL093010	B. WING		07/0	; 8/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
лі рыл м	AGNOLIA GARDEN	930 HWY 1	58 BUS E			
ALCHA M	AGNOLIA GANDLIN	WARRENT	ON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
	been a sexual assaul -He spoke with the Po alleged sexual assaul PCA notified the Adm it occurred and she w Administrator not to c -He was informed by assault occurred 2 ho was for the mental he alleged sexual assaul Telephone interview w investigator on 06/11/ -He believed the incide and a male resident w -The staff did not call Resident #1 was not streatmentThe PCA witnessed heard Resident #1 ye	who told him there had t at the facility. CA who witnessed the t and was informed that the inistrator of the incident after as instructed by the all the law enforcement. the PCA the alleged sexual ours prior to this call, which alth crisis and not the t. with the law enforcement 25 at 1:10pm revealed: lent between Resident #1 was handled inappropriately. law enforcement and sent out for medical the sexual intercourse and lling no, no, no, stop, stop.				
	-The PCA removed Resident #1 from the male resident's room and called the AdministratorIt was reported to him that the sexual assault was not reported because the Administrator advised the staff not to report it to the local law enforcementOn 06/04/25, he went to the facility to speak to the AdministratorThe Administrator told him the PCP instructed her not to report the incident and to have the male resident removed from the facility today, 06/04/25The Administrator stated the sexual encounter was consensual and that she was not informed that Resident #1 was yelling no, no, stop, stop. Interview with a SCU PCA on 06/09/25 at 10:25am revealed: -She was not working when the incident occurred					

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 39 of 87

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:		
	R WING				С	
		HAL093010	B. WING		07	//08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STATE	, ZIP CODE		
ΔΙ ΡΗΔ Μ	AGNOLIA GARDEN	930 HWY	158 BUS E			
ALI HA III	AGNOLIA GARDEN	WARREN	ITON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCED	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 273	73 Continued From page 39		D 273			
D 273	between Resident #1 -She did not think Redeciding to have consresident was "comple-Resident #1 did not ewas in front of herResident #1 had to but the line with a second 3:16pm revealed: -She was the only state the incident occurred the male residentShe had seen Resident was going into the tel-She took another result Resident #1 must have room and gone into the she heard Resident stop"When she entered the Resident #1 was learn pants down, and the line having sex with her ha	and the male resident. sident #1 was capable of sensual sex because the tely out of it." even know when her food be directed for everything. and SCU PCA on 06/09/25 at off member in the SCU when between Resident #1 and eent #1 in the hallway and evision room. sident to their room and ove come out of the television he male resident's room. #1 saying, "No, no, stop, are male resident was behind er. sident to stop and that over a chair with her male resident was behind er. sident to stop and that over and the male resident said over a chair with her male resident was behind er. sident to stop and that over and the male resident said over and the male resident said over and the male	D 273			
	AdministratorThe SCU MA told he	r to "write up" the incident. lent #1 was heard saying no,				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 40 of 87

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL093010	B. WING		C 07/08/2025
NAME OF D					1 07/06/2025
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA I 58 BUS E	TE, ZIP CODE	
ALPHA MAGNOLIA GARDEN			ON, NC 27589		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 273	Continued From page	e 40	D 273		
	"different statement" ashe had written one statement and written one statement and sta	and she refused because tatement and the like what she had written. SCU PCA on 06/10/25 at resident say he [expletive] sident punch the other SCU the male resident did not round 7:30pm and thought did then. und 9:00pm. Wed her about the incident, did her to write a statement ault.			
	Interview with a SCU MA on 06/09/25 at 10:39am revealed: -She had heard about the incident between Resident #1 and the male residentResident #1 needed assistance with everythingResident #1 did not know what was going onIf someone asked Resident #1 if she wanted to have sex, she would not even understand the question. Interview with another SCU MA on 06/09/25 at 2:53pm and 4:16pm revealed: -She was working in the SCU on 06/03/25 when the incident occurred between Resident #1 and the male resident, but she was not in the SCU at the time the incident occurredShe had stepped outside of the facility to get something out of her carTwo PCAs were working with her in the SCU the night the incident occurredThe AL MA came outside and told her she was				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 41 of 87

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 50.25 10.			
		HAL093010	B. WING		1	, 8/2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ΔΙ ΡΗΔ Μ	AGNOLIA GARDEN	930 HWY 1	58 BUS E			
ALI 11A W	AONOLIA GARDEN	WARRENT	ON, NC 27589	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	· 41	D 273			
D 2/3	needed in the SCU. -Upon return to the Sc Resident #1 was in the Resident #1 went in a rooms. -"We were told we had not restrain her." -The other PCA took to break and that was we The PCA told her she stop, and saw the mathave clothes on and versident she was not aware of Resident #1 and sexult working at the facility. -Two named staff merenforcement. -When she called the incident, she told her resident was trying to #1. -The Administrator tole enforcement until she guardian to see how thandle the situation. -The Administrator cashe had heard from the guardian said Reside behavior and they did against the male resident #1 was not able to decide to have -When EMS entered to resident, the EMS per incident with Resident with Resid	CU, the PCA told her e male resident's room. and out of other residents' ve to let her walk; we could more than a 15-minute hen the incident occurred. The heard someone hollering le resident, who did not was on top of Resident #1. Resident #1 had clothes on the start of any other incidents with hal activity since she started 5 months ago. The most of the PCA reported the male sexually assault Resident #1's he guardian wanted to to call law talked to Resident #1's he guardian and the not want to press charges dent. Oriented and would not be exexually for another resonnel were told about the tit #1 and that was how law	D 273			
	able to decide to have -When EMS entered t resident, the EMS per	e sex. The facility for another The facility f				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 42 of 87

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _			
			D WING		С	
		HAL093010	B. WING		07/08/2025	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ALPHA MAGNOLIA GARDEN 930 HWY			58 BUS E			
ALFIIA W	AGNOLIA GANDLIN	WARRENT	ON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLE	
D 273	Continued From page	e 42	D 273			
D 273	Interview with the AL revealed: -She was the MA on to 06/03/25She could hear noiseShe was administering when the SCU PCA or hysterical and stated, here" and stated she -The PCA stated that of Resident #1 and shassaulting herThe SCU PCA told here moaningWhen she went to chresident on top of Resexually assaulting herested with the SCU and the PCA told here sexually assaulting herested the SCU in the SCU and the PCA told herested the heard the herested hereste	the second shift in the AL on e coming from the SCU. Ing medications in the AL eame out of the SCU "I am the only one back needed help. a male resident was on top ne thought he was sexually her she was in a resident's sident when she heard heck, she saw a male sident #1, and he was er. PCA why she was by herself CA told her another PCA hites. Hell the Administrator who e exactly what happened, male resident was sexually e1; the PCA was crying. histrator what she wanted ministrator said "Do not call MS on the male resident in his mental status. th the Administrator about ement because the resident e could have been sexually	D 273			
	assaulted because of how aggressively the male resident was acting after the incidentWhen EMS arrived, law enforcement was with EMS.					
	to be okay with this harmonic representation to be okay with this harmonic representation and the A	nt" with her for the guardian appening to Resident #1. Administrator and told her t had punched her in the				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 43 of 87

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		LETED
						С
		HAL093010	B. WING		07/	08/2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	ODRESS, CITY, STA	TE, ZIP CODE		
		930 HWY	158 BUS E			
ALPHA M	AGNOLIA GARDEN	WARREN	ITON, NC 27589)		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRI	ECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	COMPLETE DATE
D 273	Continued From page	€ 43	D 273			
	face.					
		aid to call EMS and report a				
		Il health change but not to				
	call 911.	in realth change but not to				
	-	ith the decision not to call				
	911.					
		or (AD) called and said to				
		spected sexual assault and				
	not to bathe Resident					
	-When EMS arrived for	or the male resident, she				
	told them about Resid	dent #1 being sexual				
	assaulted.					
		alled and wanted to know				
	•	nforcement; she told the				
		not call law enforcement.				
		ated that law enforcement				
	Resident #1's normal	lled because this was				
	**	of Resident #1 having any				
	inappropriate sexual					
		sident #1 had the mental				
	capacity to consent to					
		ny anyone would be ok with				
		Resident #1 was sexual				
	assault .					
		as informed of Resident #1				
		uring the sexual act, and that				
	Resident #1 was sexi	ually assaulted.				
	Telephone interview v	with a guardian on 06/09/25				
	at 8:46am revealed:	3				
	-He was the guardian	on call on 06/03/25 when a				
	call was received fror					
	regarding Resident #	1 having sex with a male				
	resident.					
		incident was consensual				
	and was not told it wa					
	-He asked the Admini					
		ospital for a SANE exam (a				
	kit used to gather and	d preserve physical evidence				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 44 of 87

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		C
		HAL093010	B. WING	B. WING	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
ΔΙ ΡΗΔ ΜΑ	AGNOLIA GARDEN	930 HWY	158 BUS E		
7(2) 17(10)		WARREN	NTON, NC 27589		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	BE COMPLETE
D 273	Continued From page	e 44	D 273		
	following an instance assault) and the Adm consensual. -He knew the residen -He was not told the Fe be sent to the hospital -He only received one regarding this incident. Telephone interview was court-appointed guard revealed: -He saw Resident #1 -Resident #1 slept mashe walked around in -Resident #1 did not respoken to. -He received an emain representative about -The email stated the between Resident #1 sex was consensual. -He did not think Resident #1 to the Edit of the washed the received the Resident #1 to the Edit -He was not aware of hypersexual behavior. Telephone interview was aware if Resident #1 behaviors. Telephone interview was supervisor on 06/10/2 revealed: -The facility should he evaluation.	or allegation of sexual inistrator said no it was at resided in the SCU. PCP wanted Resident #1 to all to be evaluated. It call from the facility staff to a call from the staff to a call from the was there; the hallways. The sepond to questions when a call from the on-call guardian the incident on 06/03/25. The was sexual activity and a male resident and the call for evaluation and the call, he would have sent a consent cognitive ability and her call, he would have sent a call, he would have sent a call, he should be made that any hypersexual with Resident #1's guardians' and any hypersexual activity and 3:42pm are sent Resident #1 out for a call			
	-She would have had	Resident #1 sent out for			

Division of Health Service Regulation

evaluation.

STATE FORM 6899 WJSU11 If continuation sheet 45 of 87

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		HAL093010	B. WING		0.7	C 7 /08/2025
		TIAL093010			07	706/2025
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
ALPHA M	AGNOLIA GARDEN		158 BUS E			
			ITON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From page 45		D 273			
	representative they w #1 outShe or the court-app been contactedShe was not aware of hypersexualityA resident who resid incompetent and had guardian did not have sexual intercourseThis situation was not -Resident #1 should h medical treatmentShe requested that F ED for evaluation that	ed in the SCU, who was a court-appointed legal the ability to consent to be thandled properly. In ave been sent to the ED for Resident #1 be sent to the today, 06/10/25, since received medical attention				
	dated 06/10/25 revealused -Resident #1 was seed -Resident #1 was test disease (STD)Resident #1 was to rone monthResident #1 was ord treat STDs prophylace Telephone interview was Coordinator (SCC) or revealed: -She received a telephology and a telephology an	en for sexual assault. Ited for sexually transmitted Repeat the test for STDs in Rered two medications to Itically. With the Special Care In 06/09/25 at 6:41pm Inhone call from the Ine incident involving In resident. In anted to know who Resident Item as and said she would call				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 46 of 87

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL093010	B. WING		C 07/08/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	,	
		930 HWY 1	58 BUS E			
ALPHA M	AGNOLIA GARDEN	WARRENT	ON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 273	Continued From page	2.46	D 273			
D 273	to the on-call guardial was informed that the representative did not the hospital because -She did not know if F by the PCP or the MF Interview with the AD revealed: -She received a voice 06/03/25 at 5:58pm; s 7:30pmThe SCC stated she male resident had set answer the phone at know what the SCC mand who gave her phores. The PCA stated whe she saw Resident #1 and Resident #1 was something, and the migust sexShe and the SCC boor change Resident #1 -She did not know who she did not know who she did not know of Resident #1 and this male residentResident #1 walked ther bed.	lled her back after speaking in representative and she encall guardian it want Resident #1 sent to she was frisky. Resident #1 had been seen HP since the incident. on 06/10/25 at 3:11pm e message from the SCC on she returned the call around had been notified that a kual assaulted Resident #1. could not get anyone to the facility and wanted to needed to do. ade a three-way call to the one to the PCA. In she was doing rounds, in the male resident's room, saying no, help, or nale resident stated it was the told the PCA to not wash that and to call 911. In that happened after that, any other incidents between male resident or any other the halls or was sleeping on fany other incidents with	D 273			
	Interview with the Are 06/09/25 at 11:08am -She learned of the in					

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 47 of 87

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		[``			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:				
		1141 002040	B. WING	B WING		C	
		HAL093010	J0		07	//08/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE			
ALPHA M	AGNOLIA GARDEN	930 HWY	158 BUS E				
7121117111	, 101102111 071112211	WARREN	TON, NC 27589				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCED	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 273	273 Continued From page 47		D 273				
D 273	and the male residential she was told Residential had done "this" in the guardian to not send evaluated. -She did not think two consent to have sexIf a resident was say considered against the staff could have siguardian to have the surface of the guardian said to the staff could have violated they would have violated they went against him second interview with on 06/09/25 at 4:04pre-She had "learned a limorning"The PCA viewed the and that was how she administrator encouraitThe PCA was encourable to the Administrator to not linterview with the Administrat	t yesterday, 06/08/25. Int #1, and the male resident past and was told by the Resident #1 out to be residents in the SCU could ing stop, it would be resident's consent. In onot send the resident out, strongly encouraged the resident to be sent out. In the Area Clinical Director in revealed: In the Area Clinical Director in r	D 273				
	· ·	e PCA "at this point."					

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 48 of 87

STATEMEN	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
					c	
		HAL093010	B. WING		1	3/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		930 HWY	158 BUS E			
ALPHA M	AGNOLIA GARDEN		TON, NC 27589	9		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	, ID	PROVIDER'S PLAN OF CORRECT	ON	(X5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	.D BE	COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
D 273	Continued From page	e 48	D 273			
	-She talked to an on-	call guardian about the				
	incident.					
		told her with his experience				
		ity; it would probably happen				
	again and was not for					
	_	onsensual because no one ut screaming or anything.				
		told her Resident #1 had a				
	diagnosis of hypersex					
	happened before.					
	· ·	as made aware of Resident				
	#1 saying no, was the	e next day, 06/04/25, when				
	the law enforcement	detective told her about his				
	interview with the PC	A.				
	-She asked all the sta	aff that were working on				
	06/03/25 to write a st	atement about what				
	happened.					
		Resident #1 to the hospital,				
	but the guardian had					
		quested the guardian's				
		would call the guardian. I through the telemedicine				
		c communication system).				
	`	25, she told the PCP what				
	-	he PCP said it sounded like				
	she followed protocol					
		the guardian or the PCP				
	after being told the incident may have not been consensual.					
	-She thought Resider	nt #1 could make decisions				
	on what she wanted t	to do.				
	-She stated because	of Resident #1's dementia,				
	she could not make a					
	_	nt #1's PCP saw her on				
	06/04/25.	" DOD "				
		Il PCP through telemedicine				
		sent to the hospital to be				
	her sent to the hospit	ardian said he did not want				
		call PCP called Resident				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 49 of 87

STATEMEN	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
						С	
		HAL093010	B. WING		07/0	8/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
ALPHA M	AGNOLIA GARDEN	930 HWY	158 BUS E				
		WARREN	ITON, 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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
D 273	Continued From page	e 49	D 273				
	#1's guardian too bed documentedOther than asking sta about what happened further investigation of incidentShe had not been too from the law enforced detective told her about when she asked the the detective one thin PCA walked offThe staff members in statement that the resistent when the Adra 4:07pm revealed: -She did not know if the last week after the incident when the staff members in statement that the resistent when the staff members in statement that the resistent when the staff members in statement that the resistent when the staff in the st	ause of the way it was aff to write up a statement d, she had not done any or reporting related to this Id anything that she heard ment detective before the out his interviews with staff. PCA why she was telling and her another thing, the ever provided her with a sident was heard saying no, withing. ministrator on 06/10/25 at the PCP saw Resident #1 cident. ent #1 last week on a doing the right thing by tan and not sending of as requested. Excual assault was never en she was notified on					

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 50 of 87

DIVISION	n nealth Service Negu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					,	,
	HAI 093010 B. WING			07/0		
		HAL093010	J		07/0	08/2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
		930 HWY	158 BUS E			
ALPHA MA	AGNOLIA GARDEN	WARREN	TON, NC 27589	9		
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ı.	PROVIDER'S PLAN OF CORRECTIO	N.	(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE	DATE
				DEFICIENCY)		
D 273	Continued From page	e 50	D 273			
	Telephone interview v	vith Resident #1's PCP on				
	06/06/25 at 2:50pm re					
	-She was not notified	of the incident between				
	Resident #1 and the r	male resident.				
	-She had not been to	ld Resident #1 had been				
	showing signs of bein	ig hypersexual.				
		the incident happened "days				
	ago" and the resident	was not evaluated.				
	-The resident should	have been evaluated right				
	after the incident happened.					
	-She did not know if t	he guardian refused to let				
	the resident be sent to	o the hospital what could				
	have been done, but	she would have contacted				
	law enforcement.					
		orcement could at least have				
		facility on the resident to see				
	if sexual assault occu	rred.				
	Interview with Reside	nt #1's PCP on 06/10/25 at				
	9:38am revealed:					
		/ the Administrator today,				
		ent between Resident #1				
	and a male resident.					
		ated this had happened				
		e two residents and the				
		esentative did not want				
	Resident #1 sent to the					
		vere two other incidents with				
	Resident #1 and the s					
		e of the previous incidents				
	with Resident #1 was resident.	with a dillerent male				
		we har the impression it was				
	consensual.	ive her the impression it was				
		d by the Administrator that				
	Resident #1 was sayi					
		esident #1 had said no, she				
		1 and had the incident				
	investigated as a sex					
		peen granted for Resident				
	in gaaralansiiip nad k	Joon grantou for Modiuoni	- 1	1		1

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 51 of 87

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _				
			B WING		C		
		HAL093010	B. WING		07/0	8/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
ΔΙ ΡΗΔ Μ.	AGNOLIA GARDEN	930 HWY	158 BUS E				
ALI IIA III	AGNOLIA GARDEN	WARREN	TON, NC 27589				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 273	Continued From page	e 51	D 273				
D 273	#1, that meant the rescapacity to make dec-Resident #1 could had one in the facility by -Resident #1 could hawould be painful, cau an injury internally or -She was concerned on 06/03/25 and there of Resident #1 as of the -She would refer Resevaluation. Interview with Reside 10:53am revealed: -The facility did not not incident dated 06/03/25 and amale residentLast night she was proday, 06/11/25, when in Resident #1's note: -The SCC told her thawas found having sexification. The SCC did not say consensual or not, but dementia and require: -The residents had conseded redirectingResident #1 could not asked of herResident #1 could not asked of herResident #1's cognitideclinedWhen she spoke to the 106/11/25, she was not sexual assaulted or the 106/11/25, she was not sexual assaulted or the 106/11/25, show the 106/11/25, she was not sexual assaulted or the 106/11/25, show the 106/11/	sident did not have the isions on her own. ave had a sexual assault kit the forensic department. ave been dry and intercourse sing friction and could cause externally. that the incident happened e had been no assessment oday, 06/10/25. ident #1 for a gynecological int #1's MHP on 06/11/25 at otify her regarding the 25 between Resident #1 and reparing for the facility visit in she read about the incident is. at morning that Resident #1 and with a male resident. It whether the incident was at the residents had disupervision. Organitive impairment and out consent to sexual activity. Out understand a question it is such as not great, and it had the SCC that morning, it told that Resident #1 was not Resident #1 was not Resident #1 was saying	D 273				
	the hospital, Residen						

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 52 of 87

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			_		C
		HAL093010	B. WING		07/08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
ΔΙ ΡΗΔ Μ	AGNOLIA GARDEN	930 HWY 1	58 BUS E		
ALI HA III	AGNOLIA GANDEN	WARRENT	ON, NC 27589		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 273	Continued From page	: 52	D 273		
	out for medical treatm	itor Resident #1 closely ive decline. notified with incidents			
	Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable. 2. Review of Resident #7's current FL-2 dated 05/24/24 revealed: -Diagnoses included dementiaShe was ambulatoryThe orientation section was blank.				
	Review of Resident #7's care plan dated 02/05/25 revealed: -The care plan was not signed by the Primary Care Provider (PCP). -There were no performance codes documented for activities of daily living (ADL). -She was oriented, but forgetful. -She was ambulatory.				
	revealed: -Resident #7 had safe -There was document	7's ADL log dated 05/15/25 ety checks every 2 hours. tation that Resident #2 was safe every two hours from			
		obtained on 07/02/25 nera was on the outside of exit door of the dining room.			

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 53 of 87

Division of Health Service Regulation		_				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
			1			
			P WING		C	
		HAL093010	B. WING		07/0	8/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
			158 BUS E	,		
ALPHA MA	AGNOLIA GARDEN		TON, NC 27589			
			10N, NC 27503			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPI		DATE
iAO		,	IAG	DEFICIENCY)		
D 273	Continued From page	e 53	D 273			
	-There was a stoop o	utside the back door that				
	had 5 steps leading to					
		#7 was observed standing				
		door, outside of the facility,				
	with her pants around					
	-It was noted to be da					
		#7's pants were around her				
	ankles, and she twiste					
		#7 was knocking on the exit				
	•	ile standing on the stoop				
	with her pants down a					
		#7 was knocking on a				
	window air conditionir	ng unit to the right of the exit				
	door.					
		#7 was hitting her hand				
	repeatedly on the woo					
	-At 4:46am, Resident	#7 was trying to pull her				
	pants up with one har	nd while holding onto the				
	wooden rail with her o	other hand.				
	-At 4:48am, Resident	#7's pants had not been				
	pulled up.					
	-At 5:19am, Resident	#7 was hitting the window				
	air conditioning unit w					
		#7 was standing at the top				
	of the stoop; her pant					
	• • •	e dark outside the facility.				
	-There was no video f	•				
	5:31am-9:42am.	3				
	-At 9:42am, Resident #7 was standing at the top of the stoopIt was noted to be light outside the facilityAt 9:55am, Resident #7 was observed holding					
		the right side and slowly				
	moving down the step	-				
		nt #7 was observed standing				
	at the bottom of the s	teps notaing onto the				
	handrail.	47 abaamı da 41 -				
		nt #7 was observed on the				
	left side of the bottom	ı step; She was reaching				

Division of Health Service Regulation

behind her, trying to hold onto the railing.

STATE FORM 6899 WJSU11 If continuation sheet 54 of 87

STATEMENT OF DEFICIENC AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						;
		HAL093010	B. WING		07/0	8/2025
NAME OF PROVIDER OR SU	PPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ALPHA MAGNOLIA GA	RDFN	930 HWY	158 BUS E			
7(2) 117 (117) (37)		WARREN	TON, NC 27589)		
PREFIX (EACH			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273 Continued	rom page	e 54	D 273			
-The exit do and a contr working on and within service and a contracted the back do DM that Resident the contracted th	por to the of acted con the door he sight of Rein, Resider ide the boon no video or ended up, the control of th	dining room was opened, struction worker was handle at the top of the steps esident #7. In the steps esident #7 was lying on the ttom of the steps. In the ground worker wood on the ground. It the steps wood on the ground worker wood at the bottom of the he door. It the door handle, and Resident #7 ground at the bottom of the he door. It the door handle, was ck down. It the door handle worker	D 2/3			

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 55 of 87

Division of Fleatin Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
					l _	
					C	
		HAL093010	B. WING		07/08	3/2025
NAME OF D	DOVIDED OD CUDDUED	CTDEET AD	DDECC CITY CTA	TE 710 000E		
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	ILE, ZIP CODE		
ΔΙ ΡΗΔ ΜΑ	AGNOLIA GARDEN	930 HWY	158 BUS E			
, , _ , , , , , , , , , , , , , , , , ,	10.1102111 07.1112211	WARREN	TON, NC 27589			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
D 273	Continued From page	. EE	D 273			
D 213	Continued From page	: 55	52/3			
	found Resident #7 lying	ng at the bottom of the				
	steps, with her upper	body on the last step and				
	her lower body on the	ground.				
	-	y clothed but her clothes				
		because of the rain during				
	the night.	J J				
	-A physical assessme	ent was performed on				
	Resident #7 with no in					
	-Resident #7 denied h	-				
		sisted off the ground after				
	several attempts.	isted on the ground after				
	•	en inside and immediately				
		m the personal care aide				
		in the personal care alde				
	(PCA).	were noted to Decident #7				
		were noted to Resident #7				
		essment was completed				
	during the shower.	and and coefficient to be a				
		ssed and walked to her				
	room with assistance					
	-Resident #7 asked to	_				
		s required at that time.				
		to closely monitor Resident				
	#7 for any new compl	aints related to the incident.				
	Davison of David and All	71				
		7's progress notes revealed:				
	-There was no documentation of the incident/accident dated 05/15/25There was no documentation that the Mental					
	Health Provider (MHF	P) was notified of the				
	incident.					
	Review of Resident #7's MHP triage note dated					
	05/15/25 revealed:					
	-The chief complaint v	was Resident #7 continued				
	to refuse her medicat	ions.				
	-There was an order t	to discontinue all scheduled				
	medications.					
	-There was no docum	nentation that the MHP was				
	notified of Resident #	7 being found outside.				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 56 of 87

DIVISION	n Health Service Negu	iation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			1			
					С	
		HAL093010	B. WING		07/08/2025	
NAME OF B	20/4050 00 011001150	OTDEET AD	DDEGG GITY GTA	TE 710 000E		
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	I E, ZIP CODE		
ΔΙ ΡΗΔ Μ.	AGNOLIA GARDEN	930 HWY	158 BUS E			
ALI IIA W	ACITOLIA CANDLIT	WARREN	TON, NC 27589			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	()	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	IATE DATE	
				DEFICIENCY)		
			5.000			
D 273	Continued From page	e 56	D 273			
	Interview with Reside	nt #7's MHP on 06/11/25 at				
	11:06am revealed:	11t #1 3 Willi 011 00/11/23 at				
		D :1 (#7) 16				
		ner Resident #7 eloped from				
	the facility on 05/15/2	•				
	06/11/25, when she a	rrived at the facility.				
	-The staff should have	e notified her that Resident				
	#7 was found outside					
	-It was unacceptable	that Resident #7 was				
	outside of the facility.					
	-The staff should be making rounds at least every					
	hour; if the staff did not see Resident #7, they					
	•	ot see Resident #1, they				
	should look for her.					
		C on 06/10/25 at 2:46pm				
	revealed:					
	-She saw the DM run	ning to the Administrator's				
	office.					
	-The Administrator pa	ged for all assisted living				
		the back of the dining room				
	(DR).	are back or are arming reem				
	, ,	ne saw Resident #7 lying on				
	·	, ,				
		oper part of her back lying				
	on the bottom steps.					
		ction worker saw Resident				
	#7; he notified the DM	I who notified the				
	Administrator.					
	-She assessed Resid	ent #7, and no injuries were				
	identified.					
	-She attempted to rea	ach the MHP by telephone				
	but was unsuccessful					
		cation aide (MA) to try to call				
		ad not been able to speak to				
		a not been able to speak to				
	the MHP.					
	Intomious with the AI	ministrator on OG/40/05 -t				
		ninistrator on 06/10/25 at				
	4:07pm revealed:					
		truction worker came and				
	got her and the RCC	and told them there was a				
	resident outside in the					

Division of Health Service Regulation

-The DM came out also.

STATE FORM 6899 WJSU11 If continuation sheet 57 of 87

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BOILBING.			
	HAL093010	B. WING		1	8/2025
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
ALPHA MAGNOLIA GARDEN	930 HWY ²				
		ON, NC 27589			
PREFIX (EACH DEFICIE	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273 Continued From page 273	age 57	D 273			
-Resident #7 was a back onto the step -The front of Resident #1 front of Resident #1 had a step -There was stool be Resident #1 had a step -The RCC assessed injuries noted. -The PCA showere -The RCC was resident was determined by the step -She did not know a second with a step -She did not know a second with hypoxia, ceresis - Diagnoses included with hypoxia, ceresis - He needed assist dressing. Review of Resider revealed he requires bathing, dressing, review of Resider revealed he requires bathing, dressing, review of Resider revealed he requires a step - She documentation region contact with a posservation of Resider revealed hereafter - She sider - She	at the bottom of the steps, lying is. ent #7's clothing were clean; back side of her clothing. the side of her pants; there ary incontinence and no odor. eside the steps where bowel movement. It desident #7; there were no id Resident #7. ponsible for notifying the MHP. It the MHP was not notified. It is sident #7 was not interviews, and record remined Resident #7 was not infarction, and epileptic ance with bathing and it #8's care plan dated 11/14/24 and grooming. It #8's charting notes from May wealed there was no arding Resident #8's toenails odiatrist.				

Division of Health Service Regulation

-There was a buildup of debris and dried skin

STATE FORM 6899 WJSU11 If continuation sheet 58 of 87

MAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 930 HWY 158 BUS E WARRENTON, NC 27589 PREDIX		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER ALPHA MAGNOLIA GARDEN MARRIA MAGNOLIA GARDEN SUMMARY STATEMENT OF DEFICIENCES WARRENTON, NC. 27589			HAL093010	B. WING			
CALID SUMMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL PREERIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREERIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE D 273 Continued From page 58 D 273 D 273 D 273 Under and between his toes on the bottom of his left and right foot. -All of his toenalis were discolored and thick. -The first toenall on his left foot extended past the end of his toe by ½ inch. -The second toenail on his left foot bad grown over the end of the toe and were curled toward the bottom side of the toe. -The first toenail on his right foot extended past the end of his toe by ½ inch and had deep ridges in the toenail. -The second toenail on his right foot extended past the end of his toe by ½ inch and was beginning to curve under. -The furth toenail on his right foot extended past the end of his toe by ½ inch and was beginning to curve under. -The fourth toenail on his right foot extended past the end of his toe by ½ inch and was beginning to curve under. -The fifth toenail on his right foot extended past the end of his toe by ½ inch and was beginning to curve under. -The fifth toenail on his right foot extended past the end of his toe by ½ inch and was beginning to curve under. -The fifth toenail on his right foot extended past the end of his toe by ½ inch and was beginning to curve under. -The fifth toenail on his right foot extended past the end of his toe by ½ inch and was beginning to curve under. -The fifth toenail on his right foot extended past the end of his toe by ½ inch and was beginning to curve under. -The fifth toenail on his right foot was broken with one piece of the toenail extended past the end of the toenail extended past the	NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	1 07700	3/2023
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) D 273 Continued From page 58 under and between his toes on the bottom of his left and right foot. -All of his toenails were discolored and thickThe first toenail on his left foot extended past the end of his toe by ½ inch and was broken off with a small piece of toenail or his right foot extended past the end of his toe by by inch and had deep ridges in the toenail on his right foot extended past the end of his toe by ½ inch and had deep ridges in the toenail on his right foot extended past the end of his toe by ½ inch and was beginning to curve under. -The first toenail on his right foot extended past the end of his toe by ½ inch and was beginning to curve under. -The fourth toenail on his right foot extended past the end of his toe by ½ inch and was beginning to curve under. -The first toenail on his right foot extended past the end of his toe by ½ inch and was beginning to curve under. -The fourth toenail on his right foot was broken with one piece of the toenail extended past the end of his toe by ½ inch and was beginning to curve under. -The fifth toenail on his right foot was broken with one piece of the toenail extended past the end of his toe by ½ inch and was beginning to curve under.	ALPHA M	AGNOLIA GARDEN					
under and between his toes on the bottom of his left and right foot. -All of his toenails were discolored and thick. -The first toenail on his left foot extended past the end of his toe by ½ inch. -The second toenail on his left foot extended past the end of his toe by ½ inch and was curved toward the first toe. -He had a blister on top of the second toe. -The third and fourth toenails on the left foot had grown over the end of the toe and were curled toward the bottom side of the toe. -The fifth toenail on the left foot was broken off with a small piece of toenail remaining. -The first toenail on his right toe extended past the end of his toe by ½ inch and had deep ridges in the toenail. -The second toenail on his right foot extended past the end of his toe by ½ inch and was beginning to curve under. -The third toenail on his right foot extended past the end of his toe by ½ inch -The fourth toenail on his right foot extended past the end of his toe by ½ inch -The fourth toenail on his right foot extended past the end of his toe by ½ inch -The fourth toenail on his right foot extended past the end of his toe by ½ inch -The fifth toenail on his right foot was broken with one piece of the toenail extended past the end of the toenail exten	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETE
revealed: -He was not wearing shoes because they hurt his toenailsHe had not had anyone ask to cut his toenailsHe had not refused to have his toenails cutHe did not know if he had told anyone his toenails needed to be cut. Interview with a personal care aide (PCA) on	D 273	under and between h left and right footAll of his toenails we -The first toenail on h end of his toe by ¾ in -The second toenail of the end of his toe by toward the first toeHe had a blister on te -The third and fourth grown over the end of toward the bottom sid -The fifth toenail on th with a small piece of -The first toenail on h the end of his toe by in the toenailThe second toenail of past the end of his toe beginning to curve ur -The third toenail on the end of his toe by -The fourth toenail on the end of his toe by -The fifth toenail on h one piece of the toen the toe and curling ur Interview with Reside revealed: -He was not wearing toenailsHe had not had anyo -He had not know if he toenails needed to be	re discolored and thick. is left foot extended past the ich. on his left foot extended past '¼ inch and was curved op of the second toe. toenails on the left foot had if the toe and were curled de of the toe. he left foot was broken off toenail remaining. is right toe extended past '½ inch and had deep ridges on his right foot extended he by ¼ inch and was her. his right foot extended past '½ inch his right foot extended past '¼ inch and was beginning to his right foot was broken with hail extended past the end of hader. ont #8 on 06/11/25 at 9:59am shoes because they hurt his her ask to cut his toenails. ho have his toenails cut. he had told anyone his he cut.	D 273			

Division of Health Service Regulation

06/11/25 at 10:10am revealed she had not

STATE FORM 6899 WJSU11 If continuation sheet 59 of 87

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			,
		HAL093010	B. WING		07/0	, 8/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ALPHA M	AGNOLIA GARDEN	930 HWY 1 WARRENT	58 BUS E ON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	÷ 59	D 273			
	noticed Resident #8's	toenails needed to be cut.				
	Interview with the Special Care Unit Coordinator (SCC) on 06/11/25 at 10:18am revealed Resident #8 usually wore shoes, so she was not aware his toenails were long.					
	sister facility on 06/11	ninistrator/Consultant from a /25 at 1:01pm revealed the been referred out to a ls needed to be cut.				
	Attempted telephone interview with Resident #8's family member on 06/11/25 at 11:27am was unsuccessful.					
	Attempted telephone interview with a representative from the facility's contracted podiatry services on 06/11/25 at 10:50am was unsuccessful.					
	Attempted telephone interview with the facility's contracted primary care provider (PCP) on 06/11/25 at 1:25pm was unsuccessful.					
	revealed: -Diagnoses included l with behavioral distur	t #6's FL-2 dated 01/28/25 hypertension and dementia bance. be with bathing, dressing,				
		6's care plan dated 01/20/25 endent on staff assistance and grooming.				
	2025-June 2025 reve	ding Resident #6's toenails				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 60 of 87

A. BUILDING: C HAL093010 B. WING 07/08/2	/2025
D 14/11/0	/2025
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
ALPHA MAGNOLIA GARDEN 930 HWY 158 BUS E WARRENTON, NC 27589	
(XI) ID	(X5) COMPLETE DATE
D 273 Continued From page 60 D 273	
Observation of Resident #6's toenails on 06/11/25 at 9:51am 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. -He had multiple calluses on the ball of his left and right foot. -The resident's first toenail on his right foot extended past the end of the toe by ½ of an inch. -The second toenail on his right foot had grown over the end of the toe and the right side of the toenail was pushing into the underside of the toe. -The third toenail on the right foot was black, broken, and jagged. -The fourth and fifth toe on the right foot had grown over the end of the toe and was curled under the bottom side of the toe. -The resident's first toenail on his left foot extended past the end of the toe by ½ of an inch. -The second toenail on his left foot had grown over the end of the toe and was curled under the bottom side of the toe. -The rhird toenail extended past the end of the toe by ½ of an inch and grown over the end of the toe and was curled under the bottom side of the toe. -The third toenail extended past the end of the toe by ½ of an inch and was jagged. -The fourth toe on the left foot had grown over the end of the toe and was curled under the bottom side of the toe. Interview with a personal care aide (PCA) on 00/11/25 at 9:54am revealed: -She helped Resident #6 with a shower on Monday, 06/09/25. -She did not look at Resident #6's toenails. -Resident #6 would not let anyone touch his feet.	

Division of Health Service Regulation

STATE FORM WJSU11 If continuation sheet 61 of 87

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	or dorace more	IDENTIFICATION NOWIDER.	A. BUILDING: _		
		HAL093010	B. WING		C 07/08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		930 HWY	158 BUS E		
ALPHA M	AGNOLIA GARDEN	WARREN'	TON, NC 27589	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 273	Continued From page	e 61	D 273		
	#6's toenails needed	to be cut.			
	member on 06/11/25 -She expected one of to cut Resident #6's toIf Resident #6's toen podiatrist, she would for 2 months for the p facilityShe was surprised to still had not been cut. Based on observation reviews it was determinterviewable. Attempted telephone representative from the cut.	if the facility's staff members openails. ails could only be cut by a not expect the facility to wait odiatrist to return to the openails of hear Resident #6's toenails ans, interviews, and record hined Resident #6 was not interview with a ne facility's contracted			
	unsuccessful.	06/11/25 at 10:50am was			
		interview with the facility's are provider (PCP) on as unsuccessful.			
	Interview with two PC revealed the PCAs di resident's toenails, or				
	and 1:03pm revealed -The staff made nail k -Certain days of the v toenailsStaff members who of				
	nursing staff. -The last time resider	nts' toenails were cut she y, 06/06/25, or Monday			

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 62 of 87

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION	(X3) DATE S	
ANDILAN	OF CONNECTION	IDENTIFICATION NOIMBER.	A. BUILDING: _		COMIL	-120
			B WING		C	
		HAL093010	b. WING		07/0	8/2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ALPHA M	AGNOLIA GARDEN	930 HWY 1				
			ON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	e 62	D 273			
D 2/3	O6/09/25Every resident's toer see whose toenails not all the process of the cutShe remembered so nail clippers because and those were purcharmore and those and those and those and the color of the c	nails should be looked at to eeded to be cut. whose toenails had been me residents needed bigger their toenails were so thick nased. ills were trimmed by staff but to the podiatrist, but she did esidents. cheduled to be back at the 6/20/25. ents in the special care unit is were so "bad" that they atrist immediately. Is were too long, it could walking. on 06/11/25 at 10:40am dents' fingernails. ire for the residents'	U 2/3			
	physical harm and ne	glect which constitutes a				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 63 of 87

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SU COMPLE	
			-			
		HAL093010	B. WING		07/08	3/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ALPHA MA	AGNOLIA GARDEN		158 BUS E FON, NC 27589)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	: 63	D 273			
		nce with G.S. 131D-34 on				
		DATE FOR THIS TYPE A1 IOT EXCEED AUGUST 7,				
D 358	10A NCAC 13F .1004 Administration	(a) Medication	D 358	All medications should be administered a ordered. Facility will be switching to cycle 8/15 to assist in monitoring of accurate		8/15/2025
	(a) An adult care hom preparation and admin prescription and non-ply staff are in accorda (1) orders by a licens which are maintained	Medication Administration me shall assure that the nistration of medications, prescription, and treatments ance with: and prescribing practitioner in the resident's record; and on and the facility's policies		medication administration. MARs and car be audited by RCC/Director/Administrato Designee weekly x4 and monthly ongoing	r/	
	review, the facility faile	es, interviews, and record ed to ensure medications ordered for 2 of 5 sampled including a vitamin				
	The findings are:					
		t #3's current FL2 dated gnoses included dementia, and hypothyroidism.				
	vitamin D3 (a vitamin	3's signed physician's 5 revealed an order for supplement used to treat s(s) 2 tablets every morning.				
	Review of a physician	s's progress note by				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 64 of 87

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE		
AND PLAN OF CORRECT	ION	IDENTIFICATION NUMBER:	A. BUILDING:		COMF	LETED
						С
		HAL093010	B. WING		I	08/2025
NAME OF PROVIDER OR	SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
			158 BUS E			
ALPHA MAGNOLIA	ARDEN		TON, NC 27589)		
0/0/15	CLIMMADV CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORE	PECTION	0/5)
1 1 ()	ACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 358 Continue	d From page	e 64	D 358			
Resident 04/17/25 -Residen prescribe -Residen 39.9The norn 30-100. Review of medication revealed -There we tablets evadministron -Vitamin documer 04/30/25 -The vita was circle there was revealed -There we tablets evadministron -Vitamin documer 05/31/25 Review of 06/01/25 -There we tablets evadministron -Vitamin documer 05/31/25	#3's primary revealed: t #3 had a vid vitamin D t #3's vitamin mal reference of Resident # on administration time of D3 1,000 u 2 ted as administration time of D3 1,000 u 2 ted as an entry for yery morning ation time of D3 1,000 u 2 ted as administration time of D3 1,000 u 2 ted as administration time of D3 1,000 u 2 ted as administration time of D3 1,000 u 2 ted as administration time of D3 1,000 u 2 ted as administration time of D3 1,000 u 2 ted as administration time of D3 1,000 u 2 ted as administration time of D3 1,000 u 2	itamin D deficiency and was supplementation. In D level from 02/13/25 was e range for vitamin D was 23's April 2025 electronic ation record (eMAR) for vitamin D3 1,000u 2 g with a scheduled f 8:00am. Itablets every morning was nistered from 04/02/25 to 00u 2 tablets every morning MAR as not administered, but why. 23's May 2025 eMAR for vitamin D3 1,000u 2 g with a scheduled f 8:00am. Itablets every morning was nistered from 05/01/25 to 23's June 2025 eMAR from revealed: If or vitamin D3 1,000u 2 g with a scheduled f 8:00am. Itablets every morning was nistered from 05/01/25 to	D 358			

Division of Health Service Regulation

STATE FORM WJSU11 If continuation sheet 65 of 87

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY PLETED	
			A. BUILDING:			_
		HAL093010	B. WING		07	C / /08/2025
				5 710 00D5	1 0.	70072020
NAME OF P	ROVIDER OR SUPPLIER		.DDRESS, CITY, STATI Y 158 BUS E	E, ZIP CODE		
ALPHA M	AGNOLIA GARDEN		NTON, NC 27589			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	DRRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	COMPLETE DATE
D 358	Continued From page	e 65	D 358			
D 358	Observation of Reside hand on 06/09/25 at 2-Sixty tablets of vitame dispensed on 04/23/2-Forty-nine tablets reresthere was a second 1,000u that contained 06/01/25; 60 tablets on Telephone interview with facility's contracted 12:30pm revealed: Resident #3 had an an 1,000u 2 tablets every-vitamin D3 was used elderly it helped the answer as with tablets (and 30 da 1,000u were dispensed-Sixty tablets (ent #3's medications on 11:41am revealed: iin D3 1,000u were 25. mained in the punch card. punch card of vitamin D3 ii 60 tablets dispensed on emained in the punch card. with a representative from ad pharmacy on 06/09/25 at active order for vitamin D3 iy morning dated 12/10/24. If as a supplement; in the absorption of calcium. Any supply) of vitamin D3 and on 03/27/25. Any supply) of vitamin D3 and on 04/23/25. Any supply) of vitamin D3 and on 06/01/25. Any tablets left in the punch sed on 04/23/25. Int #3's PCP on 06/10/25 at any the vitamin D3 for inally ordered but thought it e she was deficient.	D 358			
	Interview with a medi	cation aide (MA) on				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 66 of 87

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE Co			SURVEY PLETED	
		7.1. 20.23.110.			С	
		HAL093010	B. WING		07	//08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
AL DUA M	ACNOLIA CARDEN	930 HWY	′ 158 BUS E			
ALPHA IVI	AGNOLIA GARDEN	WARREN	NTON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 66	D 358			
	-She administered vit daily.	refuse her medication. amin D3 to Resident #3 n why there was still vitamin				
	Coordinator on 06/10 could not explain why vitamin D3 tablets in 04/23/25; sometimes	ecial Care Unit (SCC) /25 at 3:20pm revealed she there were still so many the punch card dated MAs would start using new card before the old				
		ns, interviews, and record nined Resident #3 was not				
	Refer to interview with 3:20pm.	n the SCC on 06/10/25 at				
	Refer to interview with 06/10/25 at 4:05pm.	h the Administrator on				
	02/18/25 revealed: -Diagnoses included arthritis, major depreshypertensionThere was an order	t #4's current FL2 dated dementia, rheumatoid ssive disorder, and for senna laxative (used to omg 2 tablets at bedtime.				
	medication administrative revealed: -There was an entry for tablets at bedtime with administration time of	or senna laxative 8.6mg 2 h a scheduled				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 67 of 87

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C			SURVEY PLETED	
			A. BUILDING:			
		HAL093010	B. WING		07	C / /08/2025
NAME OF D			DDDEOG OITV OTATI	- 7ID 00DE	<u> </u>	70072020
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE Y 158 BUS E	E, ZIP CODE		
ALPHA M	AGNOLIA GARDEN	*******	NTON, NC 27589			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETE DATE
D 358	Continued From page	e 67	D 358			
	documented as admir 04/30/25.	nistered from 04/01/25 to				
	Review of Resident # revealed:	4's May 2025 eMAR				
	tablets at bedtime wit					
	administration time of	f 8:00pm. g 2 tablets at bedtime was				
		nistered from 05/01/25 to				
	Review of Resident # 06/01/25 to 06/09/25	4's June 2025 eMAR from revealed:				
	-There was an entry f tablets at bedtime wit	or senna laxative 8.6mg 2 h a scheduled				
	administration time of	f 8:00pm. g 2 tablets at bedtime was				
		nistered from 06/01/25 to				
	Observation of Resident	ent #3's medications on realed:				
	-Sixty tablets of senna on 04/10/25.	a laxative were dispensed				
	-	nained in the punch card. senna laxative available for				
	administration for Res					
		with a representative from ed pharmacy on 06/10/25 at				
	12:03pm revealed:					
	-Resident #4 had an a laxative 8.6mg 2 table	active order for senna				
	-Sixty tablets (a 30 da	ay supply) of senna laxative				
	8.6mg were dispense	ed on 01/08/25. By supply) of senna laxative				
	8.6mg were dispense	,				
		ay supply) of senna laxative				
	8.6mg were dispense	u un u4/10/25.				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 68 of 87

DIVISION	of Health Service Regu	liauon			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					С
		1141 000040	B WING		
		HAL093010	B. W		07/08/2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE	
		930 HW/	/ 158 BUS E		
ALPHA M	AGNOLIA GARDEN		NTON, NC 27589		
			110N, NC 27309		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI	()
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP	
				DEFICIENCY)	
			5.050		
D 358	Continued From page	e 68	D 358		
	-Senna laxative was i	used to treat constipation.			
	Comia laxanto mao	acca to treat concapation.			
	Telephone interview v	with Resident #4's primary			
	-	on 06/10/25 at 2:30pm			
	revealed:	511 00/ 10/20 at 2:00pm			
		nna laxative for chronic			
	constipation.				
	-She saw Resident #	4 on 04/22/25 and			
		rogress note that Resident			
	#4 also received other	~			
	constipation and desp				
		25, she still felt constipated.			
		Resident #4 could become			
		not take the medication as			
	ordered.	Thou take the medication as			
		edication aides (MA) to			
	administer medication	, ,			
	auminister medication	ns as ordered.			
	Intonvious with a MA a	on 06/10/25 at 9:00am			
	revealed:	on 00/10/23 at 9.00am			
		refuse her medication.			
		enna laxative to Resident #4			
	daily.	illia laxative to Nesidelit #4			
	-	vel movements daily; she did			
		tipation to her and did not			
	strain when she used				
	Strain when she used	Title battiloom.			
	Racad on observation	ns, interviews, and record			
		mined Resident #4 was not			
	interviewable.	Tilled Nesidelit #4 was not			
	ii itoi viewabie.				
	Refer to interview wit	h the SCC on 06/10/25 at			
	3:20pm.	11 tile 500 oli 00/10/20 at			
	υ.Ζυμπ.				
	Pefer to intension wit	h the Administrator on			
		n me Auministrator on			
	06/10/25 at 4:05pm.				
	Intervious with the O	and Care Unit (CCC)			
		pecial Care Unit (SCC)			
	Coordinator on 06/10	/25 at 3:20pm revealed:			

Division of Health Service Regulation

-She checked medications daily if they were

STATE FORM 6899 WJSU11 If continuation sheet 69 of 87

AND DLAN OF CORRECTION IDENTIFICATION NUMBER			CONSTRUCTION (X3) DATE SURVEY COMPLETED	
		HAL093010	B. WING		C 07/08/2025
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	ATE, ZIP CODE	
ALPHA M	AGNOLIA GARDEN		158 BUS E TON, NC 2758	9	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
D 358	waiting on a medicati pharmacy. -Other times, she cor audits randomly and -She did not fill out a the medication cart a Interview with the Add 4:05pm revealed: -The SCC Coordinate completing medication cart medications, checkin medications, expired sure medications were remarked. -There was a form for that should get sent to -She was concerned administered.	on to be delivered from the aducted medication cart checked dispensed dates. form when she completed udits. ministrator on 06/10/25 at or was responsible for n cart audits. audits included availability of g for out-of-date medications, and making e labeled. The medication cart audits o corporate. medications were not being that medications were	D 358		
D 377	10A NCAC 13F .1006 (a) Medications that stored in the resident safe and secure man care home's medicati procedures. This Rule is not met Based on observation reviews, the facility famedication room doo the Assisted Living (A	are self-administered and 's room shall be stored in a ner as specified in the adult on storage policy and as evidenced by: ns, interviews, and record illed to ensure the r was closed and locked in AL), and that the medication e Special Care Unit (SCU) irect supervision of a	D 377	All medication carts will be locked when not use. All med techs will be inserviced. Inserv be completed by Administrator/Director/Des Excess/left over medications will be sent ba weekly and as needed. All medications will kept behind locked doors until picked up by pharmacy. A 2 hour check will be completed medication storage doors, check sheet will be placed in 2 hour check binder. RCC/Design monitor 2 hour check daily.	ice will ignee. ck 2x ce d of

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 70 of 87

MALE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
NAME OF PROVIDER OR SUPPLIER ALPHA MAGNOLIA GARDEN WARRENTON, NC 27589 DEPOVIDER'S PLAN OF CORRECTION (EACH DESCIONANCY MUST BE PROCEEDED BY PLUL REGULATORY OR LSC IDENTIFYING INFORMATION) The findings are: 1. Observation of the SCU on 06/06/25 from 12:34pm to 12:54pm revealed: -The medication cart was unlocked. -The medication cart was unlocked. -The redication cart was unlocked. -The redication cart, exposing eye drops, nasal sprays, inhalers and multiple medication punch cards. -There were no staff in the hallway or the television room. Interview with the personal care aide (PCA) on the SCU on 06/06/25 at 12:42pm revealed: -The Resident Care Coordinator (RCC) worked as the MA colago 06/06/25 at 12:42pm revealed: -The administered medications in the SCU today, 06/06/25, because the MA called out. -She administered medication cart and went to lunch. -She did not know how the medication cart and the Key to the medication cart and unlocked it. -She had the key to the medication cart. -Ther may be a spare key in the Administrators				A. BOILDING.			
ALPHA MAGNOLIA GARDEN 930 HWY 158 BUS E WARRENTON, NO. 27589			HAL093010	B. WING		1	
CALIFICATION CASTON CAST	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) D 377 Continued From page 70 The findings are: 1. Observation of the SCU on 06/06/25 from 12:34pm revealed: -The medication cart was unlockedThe surveyor was able to open the drawers on the medication cart, exposing eye drops, nasal sprays, inhalers and multiple medication punch cardsThere were no staff in the hallway or the television room. Interview with the personal care aide (PCA) on the SCU on 06/06/25 at 12:42pm revealed: -The Resident Care Coordinator (RCC) worked as the MA today, 06/06/25She thought the RCC was at lunch. Interview with the RCC on 06/06/25 at 12:54pm revealed: -She administered medication from 11:00am to 12:15pm, locked the medication cart and went to lunchShe idin not know how the medication cart got unlocked or who unlocked itShe had the key to the medication cartThere may be a spare key in the Administrators	ALPHA M	AGNOLIA GARDEN					
The findings are: 1. Observation of the SCU on 06/06/25 from 12:34pm to 12:54pm revealed: -The medication cart was in the hallway across from the television room. -The medication cart was unlocked. -The surveyor was able to open the drawers on the medication cart, exposing eye drops, nasal sprays, inhalers and multiple medication punch cards. -There were no staff in the hallway or the television room. Interview with the personal care aide (PCA) on the SCU on 06/06/25 at 12:42pm revealed: -The Resident Care Coordinator (RCC) worked as the MA today, 06/06/25. -She thought the RCC was at lunch. Interview with the RCC on 06/06/25 at 12:54pm revealed: -She administered medications in the SCU today, 06/06/25, because the MA called out. -She administered medication from 11:00am to 12:15pm, locked the medication cart and went to lunch. -She did not know how the medication cart got unlocked or who unlocked it. -She had the key to the medication cart. -There may be a spare key in the Administrators	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETE
1. Observation of the SCU on 06/06/25 from 12:34pm to 12:54pm revealed: -The medication cart was in the hallway across from the television roomThe medication cart was unlockedThe surveyor was able to open the drawers on the medication cart, exposing eye drops, nasal sprays, inhalers and multiple medication punch cardsThere were no staff in the hallway or the television room. Interview with the personal care aide (PCA) on the SCU on 06/06/25 at 12:42pm revealed: -The Resident Care Coordinator (RCC) worked as the MA today, 06/06/25She thought the RCC was at lunch. Interview with the RCC on 06/06/25 at 12:54pm revealed: -She administered medications in the SCU today, 06/06/25, because the MA called outShe administered medication cart and went to lunchShe did not know how the medication cart got unlocked or who unlocked itShe had the key to the medication cartThere may be a spare key in the Administrators	D 377	Continued From page	e 70	D 377			
Interview with the Special Care Unit Coordinator (SCC) on 06/11/25 at 10:23am revealed: -The MA administering medication would have the keys to the medication cart and the emergency key was in the Administrator's office.		1. Observation of the 12:34pm to 12:54pm -The medication cart from the television rouThe medication cart, esprays, inhalers and cardsThere were no staff in television room. Interview with the per the SCU on 06/06/25 -The Resident Care Cas the MA today, 06/0She thought the RCC interview with the RCC revealed: -She administered medication of the complete o	revealed: was in the hallway across om. was unlocked. ble to open the drawers on exposing eye drops, nasal multiple medication punch in the hallway or the resonal care aide (PCA) on at 12:42pm revealed: Coordinator (RCC) worked 06/25. C was at lunch. C on 06/06/25 at 12:54pm edications in the SCU today, e MA called out. edication from 11:00am to medication cart and went to w the medication cart got ocked it. the medication cart. re key in the Administrators ecial Care Unit Coordinator 10:23am revealed: g medication would have eation cart and the				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 71 of 87

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		1141 000040	B. WING		C
		HAL093010	B. W. C		07/08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE	
ALPHA M	AGNOLIA GARDEN		158 BUS E		
			TON, NC 27589		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 377	Continued From page	e 71	D 377		
	for administration.	A was preparing medication ove the medications from			
	the medication cart a	nd take them or leave the room and another resident			
		ıld be harmful to residents			
		edication cart to always be			
	4:07pm revealed: -The medication cart under the direct supe -There was only one	should be locked when not rvision of the MA. set of keys to the medication nistering medications was			
	the one who had the the Administrators off -Residents could ope				
		emove medications and			
	on 06/06/25 at 3:26pr	medication room in the AL n revealed: n door was opened about 10			
	inches.	t the door, and it opened			
	fully into the medicati				
		cation punch cards lying on			
	-The refrigerator was insulin pen.	unlocked and contained 1			
		the medication room or e common area, outside the r.			
	Interview with the MA revealed:	on 06/11/25 at 9:52am			

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 72 of 87

NAME OF PROVIDER OR SUPPLIER ALPHA MAGNOLIA GARDEN STREET ADDRESS, CITY, STATE, ZIP CODE 930 HWY 158 BUS E WARRENTON, NC 27589 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL ALBUILDING: B. WING WARRENTODE B. WING B. WING DEFICIENCY B. WING DEFICIENCY B. WING DEFICIENCY B. WING DEFICIENCY PROVIDER'S PLAN OF CORRECTION (X5) COMPLE	STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 930 HWY 158 BUS E WARRENTON, NC 27589 (X4) ID PREFIX TAG CONTINUED FOR LICENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 377 Continued From page 72 B. WING PREFIX STREET ADDRESS, CITY, STATE, ZIP CODE 930 HWY 158 BUS E WARRENTON, NC 27589 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DATE D 377 Continued From page 72 D 377				A. BUILDING: _			
ALPHA MAGNOLIA GARDEN 930 HWY 158 BUS E WARRENTON, NC 27589 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 377 Continued From page 72 P30 HWY 158 BUS E WARRENTON, NC 27589 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D 377			HAL093010	B. WING			
ALPHA MAGNOLIA GARDEN WARRENTON, NC 27589 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) D 377 Continued From page 72 WARRENTON, NC 27589 ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLE DATE DEFICIENCY)	NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	FE, ZIP CODE		
WARRENTON, NC 27589 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) D 377 Continued From page 72 WARRENTON, NC 27589 ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D 377 Continued From page 72	AL DUA M	ACNOLIA CARDEN	930 HWY	158 BUS E			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 377 Continued From page 72 D 377	ALPHA WI	AGNOLIA GARDEN	WARREN	ITON, NC 27589			
	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLETE	
-She did not know how the medication room was	D 377	Continued From page	e 72	D 377			
left unlocked. -Everyone knew the code to enter on the keypad to unlock the medication room door. -The resident charts, a computer used for documentation, and the printer were in the medication room. -Any staff could have entered the medication room and left the door open. -The medication room door should always be closed; it automatically locked when the door was closed. -There were medications to be returned to the pharmacy in the medication room. -The medications in the cabinets and refrigerator were not locked; these medications would be accessible to residents who could enter an unlocked medication room. -There were many ambulatory residents on the AL hall-way that could have easily walked into the medication room. -She had seen the medication room door opened when she came to work; she would close the door. -She had told the Administrator and the Resident Care Coordinator (RCC) that the medication door was found opened several times. -The her knowledge, nothing had been done to ensure the medication door stayed closed and locked. Interview with the RCC on 06/11/25 at 1:15pm revealed: -The medication room door should be closed and locked when the MA was not in the medication room. -There were unsecured medications in the medication room and residents could walk in and take the medication.		-She did not know ho left unlockedEveryone knew the of to unlock the medication. The resident charts, documentation, and to medication roomAny staff could have room and left the dooThe medication room closed; it automatical closedThere were medication pharmacy in the medThe medications in the were not locked; thes accessible to resident unlocked medicationThere were many and AL hall-way that could medication roomShe had seen the medication roomShe had told the Adr. Care Coordinator (RC was found opened second opened se	w the medication room was code to enter on the keypad ion room door. a computer used for the printer were in the entered the medication ropen. In door should always be by locked when the door was consto be returned to the ication room. The cabinets and refrigerator e medications would be the who could enter an room. The bulatory residents on the down and the Resident consists and the Resident consists and the Resident contract and				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 73 of 87

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN (IDENTIFICATION NUMBER.		A. BUILDING: _		COMPL	EIED	
		HAL093010	B. WING		07/0) 8/2025	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
ALPHA MA	AGNOLIA GARDEN	930 HWY 1					
			ON, NC 27589				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
D 377	Continued From page	e 73	D 377				
	needed to enter the needed to enter the needed to enter the needed. She had told the staff medication room doo not want resident to gand take medications. Some of the resident take the medications. She expected the medication room. Interview with the Adri 4:07pm revealed: The medication room not under the direct some only one cart and the MA admit the one who had the the Administrator's of Resident could walk and take medications cabinet and from the She expected the medication to the staff of the staff o	nedication room. de to the keypad. If multiple times to keep the r closed because she did get into the medication room. Its were confused and could rediation room door to be gen a MA was not in the ministrator on 06/10/25 at the should be locked when should be locked when should be locked when set of keys to the medication inistering medications was keys; the extra key was in					
D 453	and Incidents 10A NCAC 13F .1212 Incidents (d) The facility shall i	2(d) Reporting of Accidents 2 Reporting of Accidents and mmediately notify the county	D 453	All required reportables will be reported with required time frame. ACE-8266^} or EQ 8266^\) a^A^] [!c^âA[AÖÙÙÁs^ACE-4] a a dæ[!EĎâ^\ Ö^•at}^^A ace A Ace Aì Ace IIA ace IIB Ace will be inservicedAs^ACE-4 a ace IIB Ace Ö^•at}^^È	}o•Á,ā∥Á &o[¦Ð ∖llstaff	8/15/2025	
	G.S. 108A-102 and the authority as required	services in accordance with ne local law enforcement by law of any mental or ect or exploitation of a					

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 74 of 87

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETI	/2025
D 14910	/2025
HAL093010 B. WING 07/08/.	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
ALPHA MAGNOLIA GARDEN 930 HWY 158 BUS E WARRENTON, NC 27589	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 453 Continued From page 74 D 453	
This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to immediately notify law enforcement for 1 of 1 resident (#1) residing in the special care unit (SCU) when the resident was allegedly exually assaulted by another resident. Review of Resident #1's current FL-2 dated 02/11/25 revealed: -Diagnoses included dementia, major neurocognitive disorder, hyperlipidemia, and pre-cliabetesShe was constantly disorientedShe was ambulatory and wandered. Review of Resident #1's care plan dated 02/04/25 revealed: -Diagnoses included major neurocognitive disorder, insomnia, seizure disorder, and dementiaShe was ambulatoryShe was ambulatoryShe was almays disorientedShe had significant memory loss; she had to be directed. Review of Resident #1's incident report dated 06/03/25 revealed: -The incident report was completed on 06/03/25 at 6:30pmThe description of the incident was a male resident was on top of Resident #1 with their clothes offThe question of whether they needed to be sent	

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 75 of 87

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
			B. WING		C	
		HAL093010	B. WING		07/08/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ΔΙ ΡΗΔ Μ	AGNOLIA GARDEN	930 HWY 1	58 BUS E			
ALITIANI	ACNOLIA GANDLIN	WARRENT	ON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 453	Continued From page	: 75	D 453			
	out for treatment was -There was no signate completed this reportThe Administrator sig Review of Resident # 06/03/25 revealed: -The Administrator rec staff member that a p had walked in on a m Resident #1.	checked as 'no'. ure of the staff who gned the report on 06/04/25. 1's progress notes dated ceived a call from the facility ersonal care aide (PCA) ale resident having sex with Illed Resident #1's on-call d them of what was				
	-The guardian informe	ed the Administrator to are provider (PCP) and keep				
	Review of the service note sheet from Resident #1's court-appointed guardianship program dated 06/03/25 at 9:18pm revealed: -The on-call guardian specialist received a telephone call from the facility's Administrator. -The Administrator provided information that Resident #1 was located in the bedroom of a male resident and was engaging in sexual activity with the male resident. -She indicated the encounter appeared to be consensual, there was no indication of coercion or force by the male resident and Resident #1 was not traumatized by the encounter. -The Administrator wanted to inform the guardian, and she stated that she would complete an incident report and would also notify the facility's PCP.					
	report dated 06/03/25 -The law enforcement	w enforcement investigation at 9:53pm revealed: t officer responded to a call le resident in the SCU with				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 76 of 87

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:				
			A. BOILDING.			•	
		HAL093010	B. WING		C 7/ 08/2025		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	-		
		930 HWY	′ 158 BUS E				
ALPHA M	AGNOLIA GARDEN	WARREN	NTON, NC 27589				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
D 453	Continued From page	e 76	D 453				
D 453	an altered mental star down and punching the Emergency Medical already on the scene resident. -The law enforcement who stated the male in Resident #1 earlier in 6:00pm. -The PCA stated she about the sexual assallaw enforcement. -EMS advised the law they had gotten in column and the PCP replied in because Resident #1 with other residents. Telephone interview will have between Resident #1 with other resident #1 06/03/25 was handled. -The staff did not call Resident #1 was not reported becautives the staff not the enforcement.	tus who was holding people nem. Services (EMS) were speaking with the male t officer spoke with a PCA resident sexually assaulted the evening, around contacted the Administrator ault and was told not to call a reforcement officer that intact with the Administrator, and spoken to the PCP, not to call law enforcement had a history of having sex with the law enforcement at 1:10pm revealed: ith the way the incident and a male resident on d. law enforcement and	D 453				
	-The Administrator tol her not to report the in male resident remove 06/04/25.	ld him the PCP instructed ncident and to have the ed from the facility today,					
	was consensual and	ated the sexual encounter that she was not informed yelling no, no, stop, stop.					

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 77 of 87

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
						С
		HAL093010	B. WING		07	7/08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
			158 BUS E	,		
ALPHA M	AGNOLIA GARDEN	WARREN	ITON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 453	Continued From page	÷ 77	D 453			
	06/09/25 at 10:39am for the male resident should be called becausing considered rape.					
	Interview with another SCU MA on 06/09/25 at 2:53pm and 4:16pm revealed: -She was working in the SCU on 06/03/25 when the incident occurred between Resident #1 and the male resident, but she was not in the SCU at the time the incident occurred.					
	something out of her -The PCA told her she	e heard someone yelling le resident, who did not				
	-Two named staff me enforcementWhen she called the	Administrator to report the the PCA reported the male				
	resident was trying to -The Administrator tol enforcement until she	sexual assault Resident #1. d her not to call law talked to Resident #1's				
	guardian to see how the guardian wanted to handle the situation. -When EMS entered the facility for another resident, the EMS personnel were told about the					
		t #1, so that was how law				
	06/10/25 at 5:11pm re	isted living (AL) MA on evealed: the second shift in the AL on				
	06/03/25.	ell the Administrator who				
	was on the telephone	ell the Administrator who exactly what happened, nale resident was raping				
		of Resident #1 saying no				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 78 of 87

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		7 BOILBING.		c
	HAL093010	B. WING		07/08/2025
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
ALPHA MAGNOLIA GARDEN 930 HWY 1 WARRENT		158 BUS E ON, NC 27589		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
cryingShe asked the Admin her to do, and the Admin her to call in a sasulted because of resident was acting affiliated because of resident was acting and self-was acting affiliated because of resident was acting and self-was acting affiliated because of resident was acting affiliated because of resident was acting and self-was acting affiliated because of resident was acting affiliated because of resident was acting and self-was acting affiliated because of resident was acting and self-was acting and self-was acting and self-was acting and self-was acting affiliated because of resident was acting and self-was acting and self-was acting affiliated because of resident was acting and self-was acting affiliated because of resident was acting and self-was acting affiliated because of resident was acting and self-was acting affiliated because of resident was acting and self-was acting affiliated because	exual act; the PCA was iistrator what she wanted ininistrator said "Do not call IS on the male resident in his mental status. In the Administrator about ement because the resident is could have been sexual how aggressively the male ter the incident. It is wenforcement was with In (AD) called the SCU MA If about the suspected rape dent #1. Ithe AD. In the male resident, she eent #1 being sexual Ited and wanted to know forcement; she told the not call law enforcement. Ited that law enforcement Ited that la	D 453		

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 79 of 87

` '	ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
HAL093010		B. WING		07/0	8/2025
NAME OF PROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 0110	0/2020
ALPHA MAGNOLIA GARDEN	930 HWY 15 WARRENTO	58 BUS E DN, NC 27589			
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST B TAG REGULATORY OR LSC IDEN'	F OF DEFICIENCIES BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
The first time she was made #1 saying no, was the next of the law enforcement detective interview with the PCA. She asked all the staff that wo 06/03/25 to write a statement happened. She wanted to send Resided but the guardian had said no Other than asking staff to we about what happened, she have any further investigation or resthis incident. She had not been told that F saying no and stop during the and the word rape was not resorted in the morning of 05/16/25 the showed where Resident #1 we stop, and that the male resident Resident #1. When she asked the PCA we the detective one thing and he PCA walked off. The staff members never prestatement that the resident we so she did not do an investigate thought the sexual act was controlled. The guardian refused to left to the hospital, she did not known as the facility of if sexual assault occurred.	lay, 06/04/25, when we told her about his were working on at about what about what the second her out. The second her with a second her with	D 453			

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 80 of 87

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLANC	OF CORRECTION	A. BUILDING:			COMPLE	ILED
		HAL093010	B. WING		07/0	8/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
AL DUA M	ACNOLIA CARDEN	930 HWY 1	58 BUS E			
ALPHA WI	AGNOLIA GARDEN	WARRENT	ON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 453	Continued From page	€ 80	D 453			
	Interview with Reside 9:38am revealed that Resident #1 had said	nt #1's PCP on 06/10/25 at				
	4:07pm revealed: -She had contacted Filter mental health provide telemedicine triage of the incident occurred the male residentShe did not know if to last week after the incident of the MHP saw Reside 106/04/25She thought she was listening to the guarding Resident #1 to the Element was in sexual assault on 06/106/106/106/106/106/106/106/106/106/1	n Tuesday, 06/03/25 after between Resident #1 and he PCP saw Resident #1 cident. lent #1 last week on s doing the right thing by ian and not sending				
D 454	and Incidents 10A NCAC 13F .1212 And Incidents (e) The facility shall a resident's responsible as indicated on the R	2(e) Reporting of Accidents 2 Reporting Of Accidents assure the notification of a person or contact person, esident Register, of the resident or his responsible ason objects to such	D 454	All responsible parties will be notified of actincidents. Staff will put who is contacted of Incident Report. Incident Reports will be reby Director/Administrator/Designee.	n the	8/15/2025

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 81 of 87

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
ANDILAN	or connection	IDENTIFICATION NUMBER.	A. BUILDING:		COM		
		HAL093010	B. WING		C 07/08/2025		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	-		
ALPHA M	AGNOLIA GARDEN	930 HWY	158 BUS E				
		WARREN	TON, NC 27589				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
D 454	medical treatment or medical evaluation, was possible but no lat time of the initial disc injury or illness by staresident's file; and (2) any incident of the elopement which doer equiring medical treatmergency medical ebe as soon as possib hours from the time of knowledge of the incidocumented in the reelopement requiring in	ness of the resident requiring referral for emergency with notification to be as soon the ter than 24 hours from the covery or knowledge of the aff and documented in the experience resident falling or eas not result in injury eatment or referral for evaluation, with notification to the le but not later than 48 of initial discovery or	D 454				
	This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the responsible party of 1 of 1 sampled resident who was found outside of the facility (#7). The findings are: Review of Resident #7's current FL-2 dated 05/24/24 revealed: -Diagnosis included dementiaShe was ambulatoryThe orientation section was blank. Review of Resident #7's care plan dated 02/05/25						
	revealed: -The care plan was n	ot signed by the Primary					

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 82 of 87

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		HAL093010	B. WING		07/08/2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
ALPHA MAGNOLIA GARDEN		930 HWY 1 WARRENT	58 BUS E ON, NC 27589		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 454	Continued From page	e 82	D 454		
	Care Provider (PCP).	mance codes documented ving (ADL). ut forgetful.			
	Review of Resident #7's ADL log dated 05/15/25 revealed: -Resident #7 had safety checks every 2 hoursThere was documentation that Resident #7 was checked on and was safe every two hours from 12:00am to 12:00pm.				
	Review of video footage from the facility's surveillance camera obtained on 07/02/25 revealed: -The surveillance camera was on the outside of the facility facing the exit door of the dining roomThe video footage was dated 05/15/25 at 4:29am.				
	-There was a stoop outside the back door that had 5 steps leading to the ground. -At 4:29am, Resident #7 was observed standing at the dining hall exit door, outside of the facility, with her pants around her thighs. -It was noted to be dark outside the facility. -At 4:32am, Resident #7's pants were around her ankles, and she twisted the doorknob. -At 4:37am, Resident #7 was knocking on the exit door of the facility while standing on the stoop with her pants down around her ankles. -At 4:44am, Resident #7 was knocking on a window air conditioning unit to the right of the exit door. -At 4:45am, Resident #7 was hitting her hand repeatedly on the wooden rail. -At 4:46am, Resident #7 was trying to pull her pants up with one hand while holding onto the wooden rail with her other hand. -At 4:48am, Resident #7's pants had not been				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 83 of 87

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		COMPLETED	
					c	;	
		HAL093010	B. WING		1	8/2025	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
930 HWY 1			,				
ALPHA MAGNOLIA GARDEN		TON, NC 27589					
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)	
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE	
TAG	REGULATORY OF L	DENTIL TING IN GRAMATION,	TAG	DEFICIENCY)	WAY E		
D 454	Continued From page	. 83	D 454				
D 101	Continued From page	5 00	5 404				
	pulled up.						
		#7 was hitting the window					
	air conditioning unit w						
		#7 was standing at the top					
	of the stoop; her pant						
		e dark outside the facility.					
	-There was no video	footage from					
	5:31am-9:42am.	# 7					
		#7 was standing at the top					
	of the stoop.	ha a catalan ahan Sanilita					
	-It was noted to be lig						
		#7 was observed holding					
	moving down the step	the right side and slowly					
		nt #7 was observed standing					
	at the bottom of the s						
	handrail.	teps floiding office the					
		nt #7 was observed on the					
		step; She was reaching					
	behind her, trying to h						
		dining room was opened,					
	and a contracted con	•					
		andle at the top of the steps					
	and within sight of Re						
	-At 10:43am, Resider						
	ground beside the bo						
	-There was no video						
	Resident #7 ended up	o on the ground.					
	-At 10:59am, the conf	racted construction worker					
	_	oor handle, and Resident #7					
		ground at the bottom of the					
	steps within sight of the						
		racted construction worker					
	continued to work on						
		ed to try to sit up but was					
	unable to and laid bad						
	The state of the s	racted construction worker					
	looked at Resident #7	and returned inside the					

Division of Health Service Regulation

-At 11:14am, the Administrator, the Dietary

STATE FORM 6899 WJSU11 If continuation sheet 84 of 87

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
		HAL093010	B. WING		C 07/08/2025				
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE					
	930 HWY 158 BUS E								
ALPHA M	AGNOLIA GARDEN	WARREN	TON, NC 27589						
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)				
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE				
D 454	Continued From page 84		D 454						
	Manager (DM), and the worker exited the facility lying on the ground -At 11:15am, the DM #7, the Administrator construction worker with the stoop, and the vident Review of Resident # dated 05/15/25 revea -The incident report with the description of the	ne contracted construction lity and observed Resident d. was standing over Resident and the contracted vere standing at the top of eo footage ended. 7's incident/accident report led: vas completed on 05/15/25							
	door of the dining roo Resident #7 was outs -The Administrator wa paged for the Resider	m and notified the DM that ide. as immediately notified and nt Care Coordinator (RCC),							
	found Resident #7 lyil steps, with her upper her lower body on the -Resident #7 was fully	a Registered Nurse (RN) ng at the bottom of the body on the last step and							
	the nightA physical assessme Resident #7 with no ir -Resident #7 denied h -Resident #7 was ass several attemptsResident #7 was take received a shower by (PCA)No apparent injuries when a full body asseduring the shower.	ent was performed on njuries noted. naving pain. sisted off the ground after en inside and immediately the personal care aide were noted to Resident #7 essment was completed							
	-Resident #7 was dre room with assistance -Resident #7 asked to								

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 85 of 87

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					С	
		HAL093010	B. WING		07/08/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ALPHA M	AGNOLIA GARDEN	930 HWY 1	58 BUS E			
	Т		ON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET	TE
D 454	Continued From page 85		D 454			
	-No further action was required at that timeStaff would continue to closely monitor Resident #7 for any new complaints related to the incidentThere was no documentation on the incident report that the court-appointed guardian was notified. Review of Resident #7's progress notes revealed: -There was no documentation of the incident/accident dated 05/15/25There was no documentation that the court-appointed guardian was notified of the incident. Telephone interview with Resident #7's court-appointed guardian on 06/11/25 at 11:35am revealed: -He did not know Resident #7 was outside the facility on 05/15/25 from 4:28am to 10:45amHe did not receive an email or voice message from the facility staffHe expected to be notified of all incidents/accident that occurred with Resident #7.					
	11:48am revealed: -She completed the ir #7 being found outsid -She called Resident guardian and left a m being found outside o -She did not documen notes that she called guardian and left a vo -She instructed the m attempt to reach the o -She did not know if t court-appointment gu	edication aide (MA) to court-appointment guardian. he MA contacted the				

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 86 of 87

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED					
AND PLAN OF CORRECTION		IDENTIFICATION NO.	A. BUILDING:							
		HAL093010	B. WING		07/0	; 8/2025				
NAME OF P	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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETE DATE					
D 454	(SCC) on 06/11/25 at -The resident's guard incident occurredShe was not aware I not notified when Res on 05/15/25Resident #7's guardi contacted about the i	ian was called each time an Resident #7's guardian was sident #7 was found outside an should have been ncident on 05/15/25 and the ave been documented on the	D 454							

Division of Health Service Regulation

STATE FORM 6899 WJSU11 If continuation sheet 87 of 87