STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345520	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB	1028 BLAIR STREET , THOMASVILLE, North Carolina, 27360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A complaint investigation survey was conducted from 7/17/25 through 7/18/25. The following intakes were investigated 2563952 and 2561095. Intake 2563952 resulted in immediate jeopardy. 1 of the 2 complaint intakes resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity J The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 3/7/25 and was removed on 3/21/25. A partial extended survey was conducted.	F0000		
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews with facility staff, resident, and the Contracted Van Transportation Company Owner, the facility failed to ensure Resident #1's wheelchair was secure on the contract transportation van lift by the Contract Van Driver before the lift platform was raised to the elevated position. On 3/7/25, Resident #1 was loaded onto the van lift by the Contract Van Driver. The lift was positioned at the rear entrance of the van and Resident #1 was facing out away from the van. When the lift platform was at the floor level of the van,	F0689	"Past Noncompliance - no plan of correction required"	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F0689 SS = SQC-J	Continued from page 1 Resident #1's wheelchair rolled forward, away from the van, and Resident #1 fell forward, off of the lift, landing on the asphalt parking lot. Resident #1 fell approximately 48 inches from the raised lift platform onto the ground. According to the resident, she had tried to put her arms out to catch herself as she was falling. Resident #1 was transported to the hospital via Emergency Medical Services (EMS) and at the hospital, Resident #1 was found to have sustained fractures to both upper arms, multiple lumbar vertebrae (lower back) fractures, and a fracture to her right foot. Resident #1 also sustained a laceration to her right forehead measuring 4 centimeters in length which required 4 sutures to close. Resident #1 was receiving a blood thinner which increased her risk of bleeding. There is a high likelihood of a serious adverse outcome, including death or injury, when the manufacturer's instructions for loading residents onto the transportation van lift are not followed. This deficient practice was found for 1 of 3 residents reviewed for accidents. The findings included: Review of the manufacturer's operating instructions showed the following instructions for the use of the contract transportation van lift to load a resident in a wheelchair. 1. Stand clear and press the unfold switch until the platform stops (reaches floor level of the vehicle - unfold fully). 2. Press the DOWN switch until the entire platform reaches ground level and the roll stop (a piece of metal attached to the lift which unfolds to a flat position when the lift is on the ground but is in an upright position when the lift is not in contact with the ground) unfolds fully (ramp position). 3. Load passenger onto platform, lock wheelchair brakes, and buckle handrail belt (if equipped). Ensure passenger is fully positioned inside the yellow boundaries. 4. Press UP switch and raise platform to floor level; approximately 48 inches from ground level to floor of van per lift manual specifications. 5. Unlock wheelchair brakes and unload passenger from platform and move into the van. Resident #1 was admitted to the facility on 8/30/18 with diagnoses included polyneuropathy (numbness and	F0689		

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F0689 SS = SQC-J	Continued from page 2 weakness in extremities), severe obesity, and a history of deep venous thrombosis. Resident #1's quarterly Minimum Data Assessment (MDS), dated 2/4/25, coded the resident as having no cognitive impairment. The resident was coded to use a wheelchair for ambulation and was dependent on staff for all activities of daily living except Resident #1 was independent with eating and oral hygiene. The MDS showed Resident #1 weighed 415 pounds. Review of the physician orders showed Resident #1 had an active order last reviewed and dated for 1/5/25 for apixaban (a blood thinner) 2.5 milligrams, take one tablet twice daily. Review of the February and March 2025 Medication Administration Record showed Resident #1 was administered the apixaban twice daily including a dose on the morning of 3/7/25. There had been no documented dose omissions from 2/1/25 to 3/7/25. Review of a statement provided to the facility by the Contract Van Driver dated 3/7/25 read in part, “I loaded the resident on the lift facing outward due to her size and the size of the wheelchair. The lift is appropriate for facing outward loading. After loading her on the lift I locked the brakes and checked them, then raised the lift to the van floor level.” The statement continued to document the driver walked around to the right side of the van to enter via the side passenger doorway. As the Contract Van Driver was walking up the steps, he noticed her (Resident #1's) chair began to roll forward toward the outside of the van. Contract Van Driver had documented he immediately moved toward her, but her chair hit the roll stop. Her momentum carried her and her wheelchair over the end of the lift where she landed on the pavement and her chair was resting on top of her. The Contract Van Driver documented he removed the wheelchair without moving the resident and at that time two unknown people arrived at her side. Contract Van Driver was unavailable for interview. An interview was conducted with Resident #1 on 7/17/25 at 10:20 AM. Resident #1 stated she was leaving the facility in a wheelchair for an appointment right after lunch on 3/7/25. Resident #1 stated the Contract Van Driver pushed her to the end of the sidewalk of the main facility entrance and loaded her onto the van lift at the back of the van. Resident #1 stated she was in a large wheelchair and felt like it took up the entire platform. Resident #1 stated she was facing the parking	F0689		

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F0689 SS = SQC-J	Continued from page 3 lot when the Contract Van Driver began to raise the lift. Resident #1 reported she felt like the wheelchair was stable on the platform but wasn't sure if the Contract Van Driver engaged the wheelchair brakes. Resident #1 explained she was trying to get the Contract Van Driver attention as the lift began to raise because she felt like the chair was beginning to roll forward as the lift was rising, but he did not hear her yelling for him. Resident #1 stated, the next thing she knew, her wheelchair began rolling forward, she fell forward off of the van lift, as she was falling she tried to catch herself with outstretched arms and hands, and she landed onto the pavement. Resident #1 did not know how far she fell but felt like it might have been several feet. Resident #1 reported she felt pain in both her arms and lower back immediately after the fall. Resident #1 stated the Director of Nursing came out and sat down on the ground with her and waited for the ambulance to arrive. Resident #1 reported she didn't want anyone to touch her—she just wanted the ambulance to get there and take her to the hospital. An interview was conducted with the Director of Nursing (DON) on 7/17/25 at 11:48 AM. The DON stated, on 3/7/25 around lunchtime, Facility Van Driver #2, who was not involved with the Contract Van Driver, or the incident, came around the corner from the front lobby to her office and stated Resident #1 appeared to have just fallen off of the van lift out front due to the resident being on the ground. The DON reported she told Facility Van Driver #2 to call 911 and she immediately went outside to assess Resident #1. The DON stated she found Resident #1 lying face down on the pavement, both of the resident's arms were under her and her wheelchair was off to the side. There was also a small laceration to the right side of her forehead. The DON stated Resident #1 was conscious, alert, crying, and stated she didn't want anyone to touch her. The DON further stated Resident #1 told her both arms and her back were hurting, therefore, the decision was made to not to move her and not assess her further until the Emergency Medical Services (EMS) arrived. The DON stated she applied a bandage to control the bleeding to the resident's forehead wound. The DON stated there were a couple of other staff members who came over to see if they could assist but she did not remember who they were. Facility Van Driver #2 was no longer employed at the facility and was unavailable for interview. An interview was conducted by phone with the Van Transportation Company Owner 7/17/25 at 12:50 PM. The	F0689		

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F0689 SS = SQC-J	Continued from page 4 Van Transportation Company Owner stated he received a call on 3/7/25 about 12:30 PM from the Contract Van Driver who told him a resident (Resident #1) just fell off the lift of the van. The Van Transportation Company Owner stated he arrived at the facility shortly after the driver called him to let him know what had happened and inspected the van and lift for any abnormalities and did not find any. Van Transportation Company Owner stated Contract Van Driver reported to him he put Resident #1 on the lift facing outward, locked the wheelchair brakes and then raised the lift up fully. The Contract Van Driver then told the Van Transportation Company Owner he walked around to the passenger side to get in the van and saw Resident #1 rolling forward out of the corner of his eye. The Contract Van Driver stated to the Van Transportation Company Owner he observed Resident #1 fall face first over the roll stop and onto the pavement below. The Van Transportation Company Owner reported the Contract Van Driver had been driving for his company for a while and completed training on using the van lift and there had no issues with the Contract Van Driver. A review of Emergency Medical Services (EMS) record showed the call was received by dispatch at 12:37 PM and EMS arrived at the facility on 3/7/25 at 12:53 PM. The record read, Resident #1 was alert and oriented and lying face down in the parking lot next to a transport bus with a superficial laceration noted to her forehead. The record further read, "The attendant apparently dropped her off the side of the ramp while she was in the wheelchair and she landed face first on the parking lot…No loss of consciousness per staff. Noted to be on a blood thinner." The record further read, assistance was needed by the local fire department in getting the resident transitioned to the stretcher and into the ambulance. Resident #1 remained alert during transport to the hospital for evaluation. A review of the hospital records for Resident #1 for the hospitalization period of 3/7/25 through 3/10/25 revealed the following: Resident # 1 was seen in the Emergency Room (ER) on 3/7/25 following the fall out of a van. The physician noted Resident #1 "was alert and in no acute distress" at the time of the physician's assessment. The physician's head to toe assessment of Resident #1 showed pain reported in both arms (splints were applied), mild back pain, and right foot pain. A 4 centimeter laceration on the forehead above the right eyebrow was closed with 4 simple sutures. Pain medication was provided. Resident #1 required no surgeries due to fractures. Diagnostic x-rays done on 3/7/25 in the Emergency Room showed Resident #1 had sustained the following fractures: 1) comminuted	F0689		

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F0689 SS = SQC-J	Continued from page 5 (fragmented) intra-articular distal humerus fracture, right elbow, 2) comminuted intra-articular distal humerus fracture, left elbow, 3) mildly displaced fractures of the left transverse processes of Lumbar (L)1 and L2 (bones which make up the lower portion of the spine), and nondisplaced fractures of the distal second and third metatarsals (the long bones of the midfoot) of the right foot. Further review of radiology reports completed on 3/7/25, indicated that a computed tomography (CT) (a CT is a noninvasive medical imaging procedure that uses x-rays to create cross-sectional detailed pictures of the inside of the body) scan of the head and neck were negative for any abnormalities. Resident #1 was admitted to the hospital on 3/7/25 for observation and was discharged back to the facility on 3/10/25 with both arms splinted and support to her right foot. A joint interview was conducted with Occupational Therapist #1 and Physical Therapist #1 on 7/17/25 at 3:30 PM. Both Occupation Therapist #1 and Physical Therapist #1 stated they had assessed Resident #1's wheelchair on 3/7/25 following the incident and found it to be in excellent working order, including the brakes working properly. Both therapists agreed that no repair issues were discovered. Occupational Therapist #1 reported, Resident #1, prior to the fall from the liftgate of the wheelchair van, was independent with both upper extremities but became dependent on staff for eating and oral hygiene following the accident on 3/7/25. Occupational Therapist #1 reported she was currently still working with Resident #1 on her hand grip and mobility. The interview further revealed Resident #1 had gained significant mobility back although the resident still required some staff assistance with reaching and picking up items. An interview was conducted with the Medical Director on 7/17/25 at 1:15 PM and she stated the DON called her immediately after the incident on 3/7/25. The Medical Director stated the DON did the right thing by not moving Resident #1 based on her presentation, her complaints of pain, and it would have taken several extra staff members to move her. The Medical Director stated she had reassessed Resident #1 several days after she was readmitted to the facility and had provided new orders to follow-up with her orthopedist in 6-8 weeks and occupational therapy as tolerated. During an interview with the Administrator on 7/18/25 at 4:30 PM, he stated the facility had not used the contract van company since the incident with Resident #1 on 3/7/25. He stated the facility transport van was unavailable that day, so they had to use an outside	F0689		

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F0689 SS = SQC-J	Continued from page 6 company. On 7/17/25 at 4:15 PM, the Administrator was notified of immediate jeopardy. The facility implemented the following corrective action plan: · Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Free of Accidents: Contract company failed to prevent fall from the van lift by not staying with the resident on the lift and not ensuring the wheelchair brakes were fully engaged. On 3/7/25 The contract van driver arrived to pick up resident #1 at approximately 12:30pm for an appointment. The contract van driver loaded resident #1 on the lift facing outward due to her size and the size of the wheelchair. Per manufacturer's instructions the lift is appropriate to load facing outward. After loading resident #1 on the lift the contract van driver stated he locked the wheelchair brakes and checked them by pushing on the wheelchair to ensure there was no movement, he then raised the lift to the van floor level. The contract driver proceeded to walk into the van via the passenger doorway. As the driver was walking up the steps of the van, he noticed Resident #1's chair began to roll forward toward the outside of the van. He immediately moved toward her on the outside of the van, but the resident's wheelchair hit the roll stop of the liftgate. Her momentum carried the resident and her wheelchair over the end of the lift where she landed on the pavement and her chair was resting on top of her. The driver removed the chair without moving resident #1 and at that time two staff members arrived at her side. The van driver asked one of them to call 911. The County Emergency Medical Service (EMS) arrived at the facility within 10 minutes and the local fire department staff arrived shortly thereafter. No injuries were identified at the scene. Resident #1 was in the hospital for 3 days for right comminuted intra-articular distal humerus fracture, left comminuted intra-articular distal humerus fracture, mildly displaced fractures of the left transverse processes of L1 and L2, non displaced fractures of the distal second and third metatarsals of the right foot, and superficial linear laceration to the right forehead measuring 4 centimeters in length requiring 4 sutures to repair. Resident required bilateral splints for left and right elbow fractures and was totally dependent on staff upon return to the facility.	F0689		

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F0689 SS = SQC-J	Continued from page 7 · Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Residents that require transport have the potential to be affected by the deficient practice. The Director of Nursing identified residents that have been transported in the last 30 days. On 3/7/25 alert and oriented residents identified were interviewed by the Administrator and asked if they had any safety concerns during transport. No residents reported having safety concerns. On 3/7/25 the Director of Nursing performed a skin check on the non interviewable residents that were identified. No injuries or signs of safety concerns were identified. · Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The contract van company owner inspected the contract van vehicle lift, tie downs, lap, and shoulder restraints for proper operation on 3/7/25. All were mechanically sound and working as intended. Education was provided per manufacturers guidelines to all 5 transportation drivers for the facility on 3/7/25 by the Director of Plant Operation about providing supervision/contact with the resident while the resident is on the lift. In addition, the Director of Plant Operations observed the transportation drivers through the loading and unloading process to show full compliance and understanding of providing constant supervision and contact with a resident when the resident is on the lift, this included safely securing a resident in the van. These observations were completed on 3/7/25. The contract van company is no longer being used. No other contract van company is being used. Newly hired transportation drivers will be required to receive the same education and return demonstration with the Regional Maintenance Director or Maintenance Director during orientation. The Administrator will be responsible for tracking the education. · Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Maintenance Director or Administrator will observe five residents being loaded into the van prior to transport at the facility and unloaded from the van	F0689		

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F0689 SS = SQC-J	Continued from page 8 upon return to the facility from the transport per week for four weeks then three residents a week for eight weeks to ensure that facility van drivers are following manufacturer's instructions for loading and unloading a resident on and off the van. This includes ensuring wheelchair brakes are locked when using the wheelchair lift, having constant supervision/contact with the resident while they are on the wheelchair lift, and safely securing the resident in the van per manufacturer's instructions. The decision was made on 3/7/25 to complete training and education, monitor the system, and to take to Quality Assurance Committee. This plan was taken to the Quality Assurance and Performance Improvement (QAPI) committee on 3/20/25 by the Administrator. The QAPI committee, which consists of the interdisciplinary team will review the audits to identify if there are any trends that need to be addressed or require an extension of the audits. · Include dates when corrective action will be completed. Alleged date of IJ removal: 3/21/25. The facility's corrective action plan was validated by the following: Only 2 of the 5 facility van drivers were still employed by the facility. The facility provided documentation of Transportation Aide/Driver #3 and Transportation Aide/Driver #4 web-based training courses on driving basics, how to anticipate potential hazards and how to react to them, and a checklist that included return demonstrations on how to load and unload residents from the transportation van. The facility provided evidence of their audits as outlined in their plan of correction. Their audits included observation of Facility Van Driver #3 and Facility Van Driver #4 to ensure both followed lift and van safety instructions regarding boarding safety, patient securement, and patient assistance. Monitoring of all residents using the transport van lift was being conducted and that information was presented in the facility's QA meeting. On 7/17/25 at 5:05 PM Facility Van Driver #3 was observed loading and unloading a staff member, who was seated in a wheelchair, from the facility van using the lift. Facility Van Driver #3 explained in detail the steps she took and the safety measures she followed when using the lift as she was loading and unloading	F0689		

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F0689 SS = SQC-J	Continued from page 9 the staff member. The observation included verification that wheelchair brakes were engaged, and the chair was secure on the lift. An interview conducted with a resident who had been recently transported to an appointment revealed he had no concerns with being loaded or unloaded from the van, being secured safely in the van, and felt the transport was safe. Facility Van Driver #3 stated she completed the refresher course as part of the facility plan of correction on 3/8/25. Facility Van Driver #3 provided a copy of a checklist which showed she used when loading and securing a resident for transport. The facility's IJ removal date and compliance date for the corrective action plan of 3/21/25 was validated. The IJ removal date was 3/21/25.	F0689		