STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063007	A. BUILDING: _____ B. WING _____	R-C 09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GARDENS	594 MURRAY HILL ROAD SOUTHERN PINES, NC 28387

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Moore County Department of Social Services conducted a follow-up survey and complaint investigations on 09/03/25-09/05/25 and 09/08/25. The complaint investigations were initiated by Moore County Department of Social Services initiated on 07/17/25, 07/29/25, 08/20/25, and 9/03/25.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure 1 of 8 sampled residents (#1) was supervised resulting in the resident being outside of the facility without staff's knowledge throughout the night after falling from his wheelchair. The findings are: Review of Resident #1's current FL2 dated 03/03/25 revealed: -Diagnoses included mild cognitive impairment, hypertension, osteoarthritis, age-related macular	D 270		

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degeneration.
-He was semi-ambulatory with a wheelchair.
-He was intermittently disoriented.
-Level of care was assisted living.

Review of Resident #1's Resident Register revealed:
-Date of admission was 08/08/22.
-There was a Power of attorney listed for Resident #1.

Review of Resident #1's care plan dated 03/03/25 revealed Resident #1 required supervision with eating, ambulation, grooming, and transfer and limited assistance with toileting, bathing, dressing.

Review of Resident #1's Licensed Health Professional Service dated 08/20/25 revealed Resident #1 required assistance with ambulation using an assistive device (wheelchair).

Review of Resident #1's Accident/Incident Report dated 07/23/25 revealed:
-The report was completed by the medication aide/supervisor (MA/S).
-The resident was located outside in the common area in the enclosed courtyard in the water on top of the rocks on 07/23/25 with no time given for the incident.
-Emergency Medical Services (EMS) were contacted.
-EMS arrived and assessed the resident who refused to go to the emergency department to be further assessed.
-The Primary Care Provider was contacted at 6:06am and responded at 6:08am.
-The Power of Attorney was contacted at 6:02am and a message was left.

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D 270	Continued From page 2 Observation on 09/04/25 at 2:36pm revealed: -The surveyor and Adult Home Specialist (AHS) exited the facility from a door near the dining room which led to the enclosed courtyard where Resident #1 had been out unsupervised on the night of 07/23/25. -There were no audible alarms when the exit door was opened. -The enclosed courtyard had a man-made stream of water which flowed through pebbles and rocks that went under a wooden bridge. -There were concrete pathways leading from the building to brick lined pathways which led to the wooden bridge. -There were various sizes of stones, ornamental grasses, shrubs and rose bushes which bordered the landscape of the stream. -There was a small wooden bridge with small vertical slats over the rocky stream bed with both ends of the bridge joined from the brick pathway. Review of the local weather report on the temperature in the area revealed: -The temperature ranged from 90 degrees to 65 degrees from 6:00pm on 07/22/25 to 6:00am on 07/23/25. -On 07/22/25 at 7:00pm, it was 87 degrees. -The sun set at 8:28pm that day (07/22/25). -On 07/23/25 at 5:00am, it was 65 degrees. Review of Resident #1's facility progress notes by the medication aide/personal care aide (MA/PCA) dated 07/23/25 at 5:53am revealed: -The resident was found outside in the common area about 5:00am, laying in the rocks under the bridge. -When asked how he got there, he said he was trying to go home to his wife. -EMS was called. -He was assessed by EMS but not sent to the	D 270		

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D 270	Continued From page 3 emergency room. Review of Resident #1's facility progress notes by the Assistant Executive Director dated 07/23/25 at 3:05pm revealed: -Following an incident report submitted on the morning of 07/23/25, the facility camera footage was reviewed and revealed that Resident #1 had exited the building overnight and remained in the courtyard for a prolonged period of time before being found during the morning rounds. -During that time, Resident #1 was observed on the camera to have fallen from his wheelchair and remained on the ground until discovered by the medication aide (MA). -EMS was called and they assisted the resident up and he declined transport to the emergency room. -Resident #1 was evaluated by the facility primary care provider (PCP) through telehealth and the PCP ordered for Resident #1 to be closely monitored and to encourage fluids. Review of Resident #1's facility progress notes by the medication aide/supervisor (MA/S) dated 07/23/25 at 11:14pm revealed: -She put Resident #1 in bed and checked on him before leaving shift. -The resident had rested and drank some liquids. -There were no other progress notes dated for 07/23/25. Interview with the MA/S on 09/08/25 at 11:10am revealed: -She was the MA/S who worked night shift on 07/22/25-07/23/25 when the incident with Resident #1 occurred. -The MA/S responsibilities were to make sure residents received their medications and that the staff were making their rounds to check on all the	D 270		

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residents.
-The MA/PCA came over to her (did not remember the exact time) on the special care unit (SCU) to tell her that she could not find Resident #1.
-The MA/PCA said the last time she remembered seeing Resident #1 was around 2:00am when she made her rounds.
-The MA/PCA said she thought Resident #1 was in bed the way that the bed covers were looked like he was in bed.
-The staff completed a room search but did not locate Resident #1.
-The staff searched the outside grounds of the facility.
-Resident #1 was found in the courtyard sitting on the ground near the bridge.
-Resident #1 was assessed and no injuries were found.
-She called emergency medical services (EMS) and left a message for the family.
-EMS arrived and checked Resident #1 and he refused to go to the emergency room.
-EMS assisted resident back into his wheelchair and he was taken back to his room.
-She completed the incident report and charting notes.

Interview with the Executive Director (ED) on 07/28/25 at 9:08am revealed:
-She received the incident report and reported it to the Division of Health Services Regulation (DHSR).
-She faxed the report on 07/24/25 to DHSR.
-The medication aide/personal care aide was interviewed and the ED reported that the last time that the MA/PCA saw Resident #1 was at 2:00 AM that morning of 07/23/25.
-She stated Resident #1 had been found outside around 5:18am in the courtyard.

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-She stated she reviewed the videos and saw Resident #1 going outside around 7:00pm on 07/22/24 and Resident #1 had not come back inside the building.
-She stated she had the MA/PCA come in and watch the video and then the MA/PCA admitted that she had not seen Resident #1 throughout the night.
-When asked about the medication being given to Resident #1 at 8:00pm, the ED stated that the medication had been given to him just prior to him going outside.
-The MA/PCA was seen taking Resident #1 to his room just prior to him exiting the building into the courtyard.
-Resident #1 made his own decisions and had refused to allow EMS to transport him to the emergency room for evaluation.
-Resident #1 had a telehealth visit with the PCP on 7/23/25 and that the PCP had ordered labs as well as a urinalysis and instructed the staff to push fluids.
-The MA/S attempted several times to contact Resident #1's POA and had left messages.
-She called Resident #1's POA to confirm if he had spoken with anyone at the facility about Resident #1 falling outside, the POA responded yes that he had received a call.

Interview with the Assistant Executive Director on 07/28/25 at 9:08am revealed:
-That on 07/22/25, Resident #1 exited the facility and entered the courtyard at 7:07pm.
-Resident #1 fell out of his wheelchair at 11:02pm and was not found until 5:18am by the medication aide / personal care aide (MA/PCA).
-Emergency Medical Services (EMS) were called and arrived around 6:09am.

Review of primary care provider notes dated

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D 270	Continued From page 6 07/23/25 revealed: -Staff reported finding Resident #1 outside in the garden courtyard around 5:15am this morning. -Patient was found sitting on the bridge with one shoe off and his foot in the water. -EMS were contacted, evaluated the resident, determined him to be competent, and the resident declined transfer to the emergency room. -Staff reported the resident was confused beyond baseline yesterday. -Staff reported his vital signs are within normal limits. -He required PRN (as needed) Seroquel (a medication used to improve mood, thoughts, and behaviors) prior to his shower this morning along with his scheduled dose which made him somewhat drowsy today. -He was not able to answer questions appropriately. -The PCP noted the treatment plan to be for encephalopathy possibly secondary to infection versus dehydration versus disease progression. -Bloodwork for complete blood count (CBC) with differential was ordered along with a comprehensive metabolic panel (CMP) and a urinalysis (UA). -The PCP "advised staff to increase fluids, monitor, and urinary output". Interview with a Resident Care Coordinator (RCC) on 09/08/25 at 1:45pm revealed: -There were 2 RCCs for the assisted living (AL) wings of the facility and one for the Special Care Unit (SCU). -The RCCs had an on-call rotation and were available to assist staff by phone on weekends or sometimes worked at the facility if staffing needs occurred. -There was a MA/S in the facility especially at	D 270		

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night.
-The MA/S was in charge of the staff and residents.
-The MA/S responsibilities were to make sure residents received their medications and that the staff were making their rounds to check on all the residents.
-If a resident was missing the staff should check every room and once all the inside of the facility was searched, then the outside of the facility should be searched.
-The MA/S should call 911 if the resident cannot be located.
-The on-call supervisor should be called as well as the administrator and the resident's family.
-When the resident was located, the resident should be assessed for injuries.
-The MA/S would complete an Incident/Accident report and document in the charting notes.

Second interview with the Assistant Executive Director on 09/05/25 at 1:30pm revealed:
-The video footage for the incident for Resident #1 being out in the courtyard was no longer available due to the length of time since the incident.
-The Adult Home Specialist (AHS) had been provided with the timeline of events.
-She would get the video timeline information from the AHS.

Second interview with the Executive Director on 09/08/25 at 3:09pm revealed:
-Resident #1 went outside into the courtyard around 7:00pm and had been outside overnight.
-He was found outside in the courtyard around 5:00am sitting against the edge of the bridge.
-Emergency Medical Service (EMS) came to assess him, but he refused to go to the emergency room.

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D 270	Continued From page 8 -The MA/S contacted the family of Resident #1 and left a message. -The primary care provider (PCP) did a telehealth visit with Resident #1. -The 24-hour report and a five-day report were completed and sent along with the incident report to the Adult Home Specialist (AHS) as well as the Division of Health Services Regulation (DHSR). -The staff were expected to make their rounds at least every two hours or more often based on the needs of the residents. -They should ensure that each resident was accounted for and that they were breathing. -If a resident was missing, the staff were to search the building. -If the resident was not located in the building, EMS should be contacted along with the primary care provider (PCP), the family, and the Administrator. Attempted telephone interviews with medication aide/personal care aide (MA/PCA) on 09/04/25 at 10:39am and 09/08/25 at 8:32am were unsuccessful and the voice mail box was full. Attempted telephone interview on 09/04/25 at 11:00am and 09/05/25 at 8:35am with Resident #1's Power of Attorney were unsuccessful. Attempted telephone interviews on 09/08/25 at 1:21pm with the Resident Care Coordinator for the assisted living hall was unsuccessful. Attempted telephone interview on 09/08/25 at 1:20pm with the other Resident Care Coordinator of the other assisted living halls was unsuccessful. _____ The facility failed to ensure a resident who had diagnosis of mild cognitive impairment was	D 270		

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D 270	Continued From page 9 supervised resulting in a resident going outside of the facility alone, falling from his wheelchair and staff was not aware that he was outside alone for 10 hours with the last 6 hours being spent on the ground after falling from his wheelchair (Resident #1). This failure resulted in neglect of a resident and constitutes a Type A1 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on September 5, 2025. CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 8, 2025.	D 270		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to ensure staff members initiated	D 271		

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cardiopulmonary resuscitation (CPR) for 1 of 1 resident who was found not breathing and without a pulse (#7).

The findings are:

Review of the facility's Resident Medical Emergency, Life Threatening policy dated 03/01/99 revealed:
-Medical emergencies will be handled with the highest priority.
-Emergency response includes call 911, check vital signs (breathing patterns and pulse), start cardiopulmonary resuscitation (CPR) if appropriate.

Review of Resident #7's current FL2 dated 09/23/24 revealed:
-Diagnoses included essential hypertension, malignant neoplasm of part of right lung or bronchus, secondary unspecified malignant neoplasm of intrathoracic lymph nodes, late onset Alzheimer's disease, gout, and insomnia.
-Resident #7's recommended level of care was assisted living facility.
-Resident #7 was ambulatory and continent of bowel and bladder.

Review of Resident #7's record revealed there was not a Do Not Resuscitate (DNR) order on file.

Review of Resident #7's Resident Register revealed an admission date of 09/30/24.

Review of Resident #7's primary care provider's (PCP) visit note dated 07/30/25 revealed past medical history included hypertension, depressive disorder, atrial fibrillation, bilateral lower extremity edema, hyperlipidemia, vitamin D deficiency,

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benign prostate hyperplasia, morbid obesity, prediabetes, and locally advanced squamous cancer of the right lung in 2020.

Review of Resident #7's current care plan dated 10/02/24 revealed:
-Resident #7 was ambulatory with a walker.
-Resident #7 required supervision with toileting, ambulation, dressing, grooming, and transfers.
-Resident #7 required limited assistance (set-up) for eating and bathing.

Review of Resident #7's August 2025 facility progress notes revealed:
-There was an entry by a personal care aide (PCA) dated 08/16/25 at 5:46pm titled incident report.
-The PCA documented that she took Resident #7 his lunch at 1:00pm.
-Resident #7 finished eating lunch at 1:15pm and told the PCA he needed to have a bowel movement.
-The PCA checked on Resident #7 at 1:20pm and found him on the bathroom floor with his walker overturned beside him.
-The medication aide (MA) called ambulance, police, and Resident #7's family.

Review of Resident #7's facility incident/accident report dated 08/18/25 revealed:
-The date of incident was documented as 08/18/25 and the time of incident was documented as 9:00am.
-The incident occurred in the bathroom.
-Description of incident was documented as staff went to help Resident #7 and found him on the bathroom floor.
-Resident #7 was not responsive, so staff alerted the supervisor, called 911, and family.
-Staff stayed with Resident #7 until emergency

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medical services (EMS) came to assist him.
-Resident #7's primary care provider (PCP) was notified on 08/16/25 at 3:00pm.

Review of the facility's security camera footage on 09/08/25 at 11:13am revealed the time stamp on the security footage was 11:42am.

Interview with the facility's Business Office Manager (BOM) on 09/08/25 at 11:15am revealed:
-The time stamp on the security footage was ahead by approximately 30 minutes of the actual time.
-She did not know how to change the time on the security cameras.
-She was unsure if the time on the security footage could be set to the correct time because the security camera system was an older system.

Review of the facility's security camera footage from 08/16/25 on 09/08/25 from 11:13am to 11:35am revealed:
-There was a time stamp of 1:14pm, the facility's wall clock was visible, and the approximate time was 12:45pm.
-The PCA pushed a rolling cart with a meal tray to Resident #7's room and took the meal tray into the room at approximately 12:45pm then immediately exited the room.
-The PCA returned to the room approximately 2 minutes later at approximately 12:47pm and exited the room at 12:47pm.
-There was a time stamp of 2:11pm, the facility's wall clock was visible, and the approximate time was 1:40pm.
-The PCA entered Resident #7's room at approximately 1:41pm and immediately ran out of the room and into the medication storage room across the hallway.

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-The PCA and MA ran out of the medication storage room and into Resident #7's room at approximately 1:42pm and both staff members immediately ran out of the room and back to the medication storage room across the hallway.
-There was a time stamp of 2:21pm, the facility's wall clock was visible, and the approximate time was 1:50pm.
-EMS personnel were seen entering Resident #7's room at approximately 1:50pm.

Review of county EMS records dated 08/16/25 revealed:
-The facility called EMS at 1:42pm on 08/16/25.
-EMS was dispatched at 1:43pm, arrived at the facility at 1:51pm, and reached Resident #7's room at 1:52pm.
-Primary impression documented was cardiac arrest.
-Initial patient acuity documented was dead without resuscitation efforts.
-Signs and symptoms documented were cardiac arrest, asystole (a medical term meaning no heart activity), respiratory arrest.
-In narrative notes, upon arrival at the facility, Resident #7 was found sitting upright against the wall in the bathroom, non-responsive and apneic (a medical term meaning not breathing).
-Resident #7 had mottling (a medical term used to describe discoloration to the skin as a result of decreased blood flow) to both feet and cyanosis (a term used to describe a blue skin tone due to a lack of oxygen) to the neck and head.
-Skin tears were noted to Resident #7's right elbow and left hand.
-Resident #7's exact down time was unknown, and staff stated they brought Resident #7 food at 1:00pm and found him unresponsive at 1:30pm.
-A 3-lead EKG was placed on Resident #7 which showed asystole on the monitor, no pulses were

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present, and Resident #7's pupils did not react to light.
-Resuscitation was documented as resuscitation-no; not attempted-considered futile.
-Resident #7's time of death was 1:53pm.

Telephone interview with the PCA on 09/05/25 at 10:58am revealed:
-She started working at the facility as a PCA in July 2025.
-Resident #7 required assistance with dressing, grooming, and bathing.
-Resident #7 ambulated independently with a walker and did not need assistance with toileting.
-Resident #7 ate meals in his room and was able to feed himself.
-She was working at the facility on 08/16/25 and was assigned to care for Resident #7.
-She thought Resident #7's skin color appeared grey that morning and she asked him how he felt, and he told her that he felt fine, but he was cold and told her to turn the air conditioner off for him.
-She reported to the MA that she did not think Resident #7's skin color looked right.
-She took Resident #7's lunch meal tray to his room at approximately 1:00pm on 08/16/25.
-She went back to get Resident #7's lunch tray around 1:15pm and asked him if he was ready to take a shower.
-Resident #7 said he needed to use the bathroom first and then he would be ready to take his shower, so she walked with him to the bathroom and left his room.
-Resident #7 was sitting on the toilet when she left the room, but he normally was able to get on and off the toilet without assistance.
-When she returned to Resident #7's room about 5-10 minutes later, Resident #7 was on the floor in the bathroom in a slouched position with his head against the door that led to another

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resident's room.
-She touched Resident #7 and his skin felt cold and his color did not look right to her, so she yelled for the MA and then ran to find her.
-She found the MA in the medication room, and they both ran to Resident #7's room for the MA to check on him.
-She did not start performing CPR on Resident #7 because she did not know how to do CPR.
-She did not have current CPR certification.
-She had never taken a CPR course, even before she started working at the facility.
-The MA went and made phone calls but did not start CPR on Resident #7.
-She did not observe any staff members initiate CPR on Resident #7.
-EMS arrived at the facility approximately 10-15 minutes after she found Resident #7 on the floor.

Interview with the MA on 09/08/25 at 10:07am revealed:
-She was working on 08/16/25 and was assigned to the hall where Resident #7 resided.
-She did not receive any reports from the PCA or Resident #7 that he was not feeling well on 08/16/25.
-The only complaint Resident #7 had that morning was that he needed to have a bowel movement, and she explained that she was administering a medication to help with constipation.
-On 08/16/25, she last saw Resident #7 sitting in his room around 11:30am and he asked her to assist him with a television remote.
-She thought the PCA took Resident #7 his lunch meal tray around 12:30pm that day, 08/16/25.
-The PCA reported to her that when she returned to Resident #7's room, he told her that he needed to use the bathroom, so the PCA escorted him to the bathroom, and he was on the toilet when the

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D 271	Continued From page 16 PCA left the room. -When the PCA returned to the room, she found Resident #7 on the floor and the PCA immediately came to find her. -When she entered Resident #7's room, she checked his pulse and he did not have a pulse and did not appear to be breathing, so she left the room to call EMS. -When she was on the phone with the emergency dispatch operator, they did not give her any instructions of what to do for Resident #7. -The operator asked her if Resident #7 could be helped and she told the operator Resident #7 was dead. -She did not check to see if Resident #7 had a DNR order. -She did not return to Resident #7's room and initiate CPR on Resident #7. -She did not initiate CPR on Resident #7 because he was already dead and the PCA was upset. -When EMS arrived at the facility, they performed an electrocardiogram (EKG) on Resident #7 and he was pronounced deceased by EMS. -She reported the incident to the Resident Care Coordinators (RCCs) and the Administrator. -The police also came to the facility, and she called Resident #7's family after the police told her it was fine to call. -She had current CPR certification and took the course at the facility in 2024. -She was trained in the course that if someone was not breathing and did not have a pulse to check their code status and start CPR and chest compressions. -The facility had CPR face shields available for staff to use in the event they needed to start CPR for a resident. Interview with a RCC on 09/08/25 at 1:29pm revealed:	D 271		

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D 271	Continued From page 17 -There were 2 RCCs for the assisted living (AL) wings of the facility and one for the Special Care Unit (SCU). -The RCCs had an on-call rotation and were available to assist staff by phone on weekends or sometimes worked at the facility if staffing needs occurred. -She was not on-call the weekend of 08/16/25. -The facility always had at least one staff member on each shift who was certified in CPR. -Residents' code status could be found on their face sheets and in their charts. -The facility had CPR face shields available on the supervisor's key rings and in the medication cart. -If staff members found a resident without a pulse and not breathing, the resident's code status should be checked, and CPR should be started immediately. -Any staff member could contact EMS, but the supervisor should be made aware of any issues with residents. -She was aware Resident #7 expired at the facility on 08/16/25. -The staff did not start CPR on Resident #7 on 08/16/25 but should have. -She was unsure why the staff did not start CPR on Resident #7. -If a resident was full code status, staff members should always start CPR if a resident was found not breathing and without a pulse. -Even if a resident appeared to be deceased, the staff should still start CPR if the resident did not have a DNR order. -Once the staff started CPR, they should not stop until EMS arrived at the facility. Telephone interview with the Special Care Coordinator (SCC) on 09/08/25 at 2:31pm revealed:	D 271		

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-She was on-call for the facility on 08/16/25.
-She received a call from the MA sometime in the afternoon on 08/16/25 and was told the PCA found Resident #7 unresponsive in his room.
-She asked the MA if Resident #7 had a DNR order, and the MA did not know.
-She told the MA to check Resident #7's code status and start CPR if he was a full code.
-The MA told her that she would check Resident #7's code status and call her back later.
-She was unsure why the MA did not start CPR on Resident #7.
-When the MA called back a short time later, she asked if she needed to call Resident #7's family.
-The MA thought Resident #7 was dead, but she informed the MA that she could not make that determination because a MA could not pronounce a resident's death.
-She instructed the MA to wait until EMS pronounced Resident #7 before she called his family and informed them he was dead.
-One of the staff members should have started CPR for Resident #7 and anyone in the facility could have called EMS.
-The facility was required to have a staff member who was CPR certified on shift at all times.
-If a staff member had their CPR certification, they should start CPR if a resident was not breathing and did not have a pulse.
-If a staff member did not know how to do CPR and found a resident who was unresponsive, they should tell one of the MAs immediately.
-CPR should continue until EMS arrived at the facility.
-She was unsure which staff members had current CPR certifications in the facility.
-There were CPR face shields on the supervisor's key ring and medication carts.
-MAs should notify the RCC, SCC, and the Administrator when there was an emergency with

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a resident.

Interview with the Administrator on 09/08/25 at 3:09pm revealed:
-When PCAs find a resident who is in an emergency situation, the PCAs should notify the MA immediately.
-The facility usually had at 1 or more staff members on each shift who were CPR certified.
-There were employees in various departments including housekeeping, dietary, and management who were CPR certified.
-The facility had CPR face shields on the medication carts and in the offices.
-Information regarding the residents' code status was on their face sheets and in their charts.
-On 08/16/25, she received a call from the MA, and she was informed Resident #7 died.
-She was unsure of the time, but EMS and the local police were already at the facility when she was contacted.
-When EMS was contacted, police officers also often responded to the call.
-She asked the MA if she performed CPR and the MA told her no.
-She then asked the MA why she did not perform CPR, and the MA said Resident #7 was already dead.
-She explained to the MA that she could not make the determination that a resident was dead.
-She thought there may have been some confusion related to Resident #7's current health status because his PCP discussed the potential need for hospice services recently.
-The MA should have contacted EMS and started CPR on Resident #7.
-MAs should notify her, the resident's family, and the resident's PCP when an emergency arises.

Telephone interview with Resident #7's PCP on

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D 271	Continued From page 20 09/08/25 at 2:27pm revealed: -Resident #7 had a history of lung cancer and she felt that based on a recent chest x-ray, the cancer had returned. -The chest x-ray showed Resident #7's right lung appeared to be completely occluded (An occlusion on a chest x-ray indicates a hazy area that suggests something other than air is in the lung tissue such as blood, fluid, or tissue). -She felt that a hospice referral would have been appropriate for Resident #7 and planned to order a referral during her next visit to the facility. -She was notified by the facility via phone on 08/16/25 that Resident #7 was found without a pulse and not breathing. -She thought Resident #7 had a DNR order, but she reviewed Resident #7's records and she was unable to find any documentation of a DNR order. -She was unsure what the facility's policy was regarding the staff's response to resident emergencies and when the staff should initiate CPR. -If someone did not have a DNR order and was found unresponsive, CPR would usually be started. -She was CPR certified and if she encountered someone who was unresponsive, she would begin CPR. _____ The facility failed to provide immediate care and intervention to a resident (#7) who was found not breathing and without a pulse. Resident #7 was found on the floor with no pulse and not breathing at approximately 1:41pm and staff who were certified in cardiopulmonary resuscitation (CPR) failed to initiate CPR on Resident #7. When emergency medical services (EMS) personnel arrived at the resident's room 11 minutes later at 1:52pm, Resident #7 was found in a sitting position on the floor of the bathroom, with no	D 271		

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D 271	Continued From page 21 heart activity noted on electrocardiogram (EKG), not breathing, and with discoloration to his face and feet. EMS personnel pronounced Resident #7 dead at 1:53pm on 08/16/25. This failure resulted in neglect of a resident and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/05/25 for this violation. CORRECTION DATE FOR TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 8, 2025.	D 271		
D 443	10A NCAC 13F .1208 (c) Death Reporting Requirements 10A NCAC 13F .1208 Death Reporting Requirements (c) A written notice containing the information under Paragraph (d) of this Rule shall be made within three days of any death resulting from violence, accident, suicide or homicide. (d) Written notice may be submitted in person or by telefacsimile or electronic mail. If the reporting facility does not have the capacity or capability to submit a written notice immediately, the information contained in the notice may be reported by telephone following the same time requirements under Subparagraphs (b) and (c) of this Rule until such time the written notice may be submitted. The notice shall include at least the following information: (1) Reporting facility: Name, address, county, license number (if applicable), Medicare/Medicaid provider number (if applicable), facility administrator and telephone number, name and title of person preparing report, first person to	D 443		

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learn of death and first staff to receive report of death, and date and time report prepared;
(2) Resident information: Name, Medicaid number (if applicable), date of birth, age, sex, race, primary admitting diagnoses, and date of most recent admission to an acute care hospital.
(3) Circumstances of death: place and address where resident died, date and time death was discovered, physical location decedent was found, cause of death (if known), whether or not decedent was restrained at the time of death or within 7 days of death and if so, a description of the type of restraint and its usage, and a description of events surrounding the death; and
(4) Other information: list of other authorities such as law enforcement or the County Department of Social Services that have been notified, have investigated or are in the process of investigating the death or events related to the death.
(e) The facility shall submit a written report, using a form pursuant to G.S. 131D-34.1(e). The facility shall provide, fully and accurately, all information sought on the form. If the facility is unable to obtain any information sought on the form, or if any such information is not yet available, the facility shall so explain on the form.
(f) In addition, the facility shall:
(1) Notify the Division of Facility Services immediately whenever it has reason to believe that information provided may be erroneous, misleading, or otherwise unreliable;
(2) Submit to the Division of Facility Services, immediately after it becomes available, any information required by this rule that was previously unavailable; and
(3) Provide, upon request by the Division of Facility Services, other information the facility obtains regarding the death, including, but not

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D 443	Continued From page 23 limited to, death certificates, autopsy reports, and reports by other authorities. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to provide a written death notification for 1 of 1 resident within 3 days resulting of an accident to the Division of Health Service Regulation (DHSR) when he was found on the bathroom floor not breathing and without a pulse and subsequently died (#7). The findings are: Review of Resident #7's current FL2 dated 09/23/24 revealed: -Diagnoses included essential hypertension, malignant neoplasm of part of right lung or bronchus, secondary unspecified malignant neoplasm of intrathoracic lymph nodes, late onset Alzheimer's disease, gout, and insomnia. -Resident #7's recommended level of care was assisted living facility. -Resident #7 was ambulatory and continent of bowel and bladder. Review of Resident #7's Resident Register revealed an admission date of 09/30/24. Review of Resident #7's primary care provider's (PCP) visit note dated 07/30/25 revealed past medical history included hypertension, depressive disorder, atrial fibrillation, bilateral lower extremity edema, hyperlipidemia, vitamin D deficiency, benign prostate hyperplasia, morbid obesity, prediabetes, and locally advanced squamous cancer of the right lung in 2020.	D 443		

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Review of Resident #7's August 2025 facility charting notes revealed:
-There was an entry by a personal care aide (PCA) dated 08/16/25 at 5:46pm titled incident report.
-The PCA took Resident #7 his lunch at 1:00pm.
-Resident #7 finished eating lunch at 1:15pm and told the PCA he needed to have a bowel movement.
-The PCA checked on Resident #7 at 1:20pm and found him on the bathroom floor with his walker overturned beside him.
-The medication aide (MA) called ambulance, police, and Resident #7's family.
-There were no other entries for 08/16/25.

Review of Resident #7's facility incident/accident report dated 08/18/25 revealed:
-The date of incident was documented as 08/18/25 and the time of incident was documented as 9:00am.
-The incident occurred in the bathroom.
-Description of incident was documented as staff went to help Resident #7 and found him on the bathroom floor.
-Resident #7 was not responsive, so staff alerted the supervisor, called 911, and family.
-Staff stayed with Resident #7 until emergency medical services (EMS) came to assist him.
-Resident #7's primary care provider (PCP) was notified on 08/16/25 at 3:00pm.

Review of county EMS records dated 08/16/25 revealed:
-The facility called EMS at 1:42pm on 08/16/25.
-EMS was dispatched at 1:43pm, arrived at the facility at 1:51pm, and reached Resident #7's room at 1:52pm.
-Primary impression documented was cardiac arrest.

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MAGNOLIA GARDENS	594 MURRAY HILL ROAD SOUTHERN PINES, NC 28387

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 443	Continued From page 25 -Initial patient acuity documented was dead without resuscitation efforts. -Signs and symptoms documented were cardiac arrest, asystole (a medical term meaning no heart activity), and respiratory arrest. -In the section titled narrative notes, upon arrival at the facility, Resident #7 was found sitting upright against the wall in the bathroom, non-responsive, and apneic (a medical term meaning not breathing). -Resident #7 had mottling (a medical term used to describe discoloration to the skin as a result of decreased blood flow) to both feet and cyanosis (a term used to describe a blue skin tone due to a lack of oxygen) to the neck and head. -Skin tears were noted to Resident #7's right elbow and left hand. -Resident #7's exact down time was unknown, and staff stated they brought Resident #7 food at 1:00pm and found him unresponsive at 1:30pm. -A 3-lead EKG was placed on Resident #7 which showed asystole on the monitor, no pulses were present, and Resident #7's pupils were fixed did not react to light. -Resuscitation was documented as resuscitation-no; not attempted-considered futile. -Resident #7's time of death was 1:53pm. Interview with the Administrator Executive Director on 09/04/25 at 2:45pm revealed: -She did not complete the written death report because she did not think the death was related to violence, accident, suicide or homicide. -She did not know a written death report should have been sent to the Division of Health Service Regulation. -She was responsible for ensuring written death reports were completed.	D 443		