STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092180	A. BUILDING: _____ B. WING _____	R 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GLEN	3215 CREEDMOOR ROAD RALEIGH, NC 27612

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual, and follow-up survey on March 04 - 05, 2026.	D 000		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to observe 1 of 5 sampled resident (#1) take their medication. The findings are: Review of the facility's medication pass policy dated 12/05/25 revealed: -The MA was to observe the residents and confirm all medications were consumed. -No medication was to be left with the resident to self-administer later. Review of Resident #1's current FL-2 dated 07/22/25 revealed diagnoses included syncope, osteoarthritis, muscle weakness of the extremities, abnormal gait, and glaucoma.	D 366		

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D 366	Continued From page 1 Review of Resident #1's physician's orders dated 02/10/26 revealed: -There was an order for Aspirin 81mg tablet, take 1 tablet daily. -There was an order for Vitamin B-12 1000mcg tablet, take 1 tablet daily. Review of Resident #1's March 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Aspirin 81mg, take 1 tablet scheduled at 9:00am. -There was an entry for Vitamin B-12 1000mcg, take 1 tablet daily scheduled at 9:00am. -The MA documented the Aspirin 81mg and Vitamin B-12mcg were administered on 03/04/26 at 9:00am. Observation during the initial tour between 9:01 and 9:10am revealed: -The surveyor and the medication aide (MA) entered Resident #1's room. -Resident #1 was lying in bed. -The MA left the room while the surveyor spoke with Resident #1. -At 9:10am, the MA returned to the room and put a medication cup and a cup of water on Resident #1's table. -The MA did not inform Resident #1 she placed the medication cup and cup of water on the table. -The surveyor and the MA left the room. Interview with Resident #1 on 03/04/26 at 9:15am revealed she took two pills every morning that were left on her table. Interview with the MA on 03/04/26 between 9:10am and 9:20am revealed: -There was an Aspirin and a Vitamin B-12 in the medication cup she left in Resident #1's room.	D 366		

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D 366	Continued From page 2	D 366		

-It was common practice for her to leave Resident #1's medications in her room.
-If she attempted to administer Resident #1's medications early, there was a problem and if she attempted to administer her medications late, there was a problem.
-Resident #1 did not like to get up early.
-Her supervisor, the Assisted Living Director, told her to administer Resident #1's medications at 9:00am per the resident's request.
-She was not supposed to leave Resident #1's medications in her room but her supervisor was aware she left them.
-After she left the medications in the room she would go back to see if the resident took them.
-She was not certain if Resident #1 took her medications, but she would ask the resident and she would state that she took them.

Interview with the Assisted Living Director on 03/04/26 at 10:12am revealed:
-She was a licensed practical nurse (LPN).
-She supervised the facility's MAs.
-The MAs should watch a resident take their medications for safety concerns and because they are signing off that it was given.
-She was not aware the MAs were leaving Resident #1's medications on her table for her to take later.
-The MAs should not leave medications in a resident's room.
-It was not the facility's policy to administer medications without observing the resident take them.

Interview with the Administrator on 03/04/26 at 1:21pm revealed:
-The MAs should not leave medications in a resident's room due to safety and security because the resident may not take the medication

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D 366	Continued From page 3 at the correct time or may double up and take the medication the next day with other medication. -The MAs should stay with a resident when they were administering medications to ensure the resident was taking the medication. Attempted telephone interview with Resident #1's primary care provider on 03/05/26 at 8:22am was unsuccessful.	D 366		