STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL031-038	B. WING		08/1	5/2018
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
MAGNO	MAGNOLIA GROUP HOME 240 NORTH PETERSON STREET MAGNOLIA, NC 28453					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	ΓS	V 000			
	2018. Deficiencies This facility is licens	sed for the following category: 000C Supervised Living for				
V 112	10A NCAC 27G .02 TREATMENT/HABI PLAN (c) The plan shall be assessment, and in legally responsible of admission for clie receive services be (d) The plan shall in (1) client outcome(achieved by provision projected date of accept (2) strategies; (3) staff responsible (4) a schedule for a annually in consultar responsible person (5) basis for evaluation outcome achievement (6) written consent responsible party, consultar	de developed based on the partnership with the client or person or both, within 30 days ents who are expected to yond 30 days. Include: (a) that are anticipated to be on of the service and a chievement; (b) the plan at least attion with the client or legally or both; (a) attion or assessment of	V 112			

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	MHL031-038	B. WING		08/	15/2018	
NAME OF PROVIDER OR SUPPLIE	240 NOR	DRESS, CITY, S TH PETERSO IA, NC 2845				
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
Based on record facility failed to im supervision based three audited clie Review on 8/15/1 - 55 year old male - Diagnoses included Intellectual Devel - Person Centere 9/12/17 by all res - No documentatic client #1's ability to Review on 8/15/1 Plan dated 10/2/1 - "What's Import #1] to practice his Hall. [Client #1] Kingdom Hall to pand Sundays for - "How Best to shumble spirit, he some others; more [Client #1] belong denomination and has told [client #1 goes to worship, he makes" - "[Client #1] repronfused and is for thinks he hears by they are just 'thouse Review on 8/15/1 Community Recression - 6/30/18 revealed.	net as evidenced by: reviews and interviews, the plement strategies for d on assessment for one of ints (#1.) The findings are: B of client #1's record revealed: admitted on 10/4/14. de Schizophrenia and Mild interpretate i	V 112				

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STATE FORM 6899 GUC911 If continuation sheet 2 of 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL031-038	B. WING		08/1	5/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	<u> </u>	
MAGNO	LIA GROUP HOME	240 NORT	H PETERSO	ON STREET		
MAGNO	LIA GROOT TIOME	MAGNOLI	A, NC 2845	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 112	P		V 112			
	- "Date: 4/5/18: Lo Rose Hill, NC; Recr - "Date: 4/8/18: Lo Rose Hill, NC; Recr - "Date: 4/22/18: I Rose Hill, NC; Recr - "Date: 4/26/18: I Rose Hill, NC; Recr - "Date: 5/6/18: Lo Rose Hill, NC; Recr - "Date: 5/6/18: Lo Rose Hill, NC; Recr - "Date: 5/20/18: I Rose Hill, NC; Recr - "Date: 5/27/18: I Rose Hill, NC; Recr - "Date: 6/3/18: Lo Rose Hill, NC; Recr - "Date: 6/3/18: Lo Rose Hill, NC; Recr - "Date: 6/17/18: I Rose Hill, NC; Recr - "Date: 6/17/18: I Rose Hill, NC; Recr - "Date: 6/24/18: I Rose Hill, NC; Recr	The state of the s				
	who picked him up - He liked going to	p service with church member at the facility. worship at the Kingdom Hall. ms when he was at the				
	Coordinator stated: - Client #1's family picked him up were take him to service - Staff checked to fi	had said the people who family friends and okay to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		MHL031-038	B. WING		08/1	5/2018
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAGNO	LIA GROUP HOME		H PETERSO A, NC 2845			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 112	- She was not awar client #1. Interview on 8/15/1. Professional (QP) so the client #1 had no punsupervised time or the Hall and the church responsible for client attendance. The faverbally that these of trusted with client # documentation to supervision. She do supervision of client his paid support tears.	e of any unsupervised time for 8, the Facility Qualified stated: prior authorization for of any amount. worship services at Kingdom members had been at #1 while he was in amily had indicated to her church members were to be 11 however there was no upport the release of id recognize that the t #1 should be a member of	V 112			

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