RECEIVED
By DHSR - Mental Health Lic. & Cert. Section at 10:58 am, Feb 04, 2019

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-315	A. BUILDING: ______ B. WING ______	12/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEILA'S MAGNOLIA PLACE	1619 FAIRFIELD DRIVE GASTONIA, NC 28054

(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
V 000	INITIAL COMMENTS An annual survey was attempted on 12/11/18. Director revealed no clients had been served at the facility who received "27G .5100 Community Respite Services. since May 2018." This facility is licensed for the following service category: 10A NCAC 27G .5100 Community Respite Services. Interview via phone on 12/11/18 with the Director revealed: -Current client being served at the facility was receiving emergency placement services authorized by the Managed Care Organization (MCO) not Community Respite Services as licensed to serve; -Client receiving emergency placement services had been admitted on 11/30/18 at approximately 7:00pm.	V 000	V 269 Rule not met based on home was licensed for Facility Respite Services and Residential Supports was provided due to an emergency placement occurred on 12/1/18 requested by Partners and Phoenix Counseling. Consumer was in an RHA AFL placement prior and RHA was able to place consumer in the Respite Facility due to facility was closed in May 2018. Permanent placement was found on January 2nd for the consumer. Updated treatment plan was emailed on 1/17/19 and is attached to this POC.	
V 269	27G .5001 Facility Based Crisis - Scope 10A NCAC 27G .5001 SCOPE (a) A facility-based crisis service for individuals who have a mental illness, developmental disability or substance abuse disorder is a 24-hour residential facility which provides disability-specific care and treatment in a non-hospital setting for individuals in crisis who need short-term intensive evaluation, or treatment intervention or behavioral management to stabilize acute or crisis situations. (b) This facility is designed as a time-limited alternative to hospitalization for an individual in crisis. This Rule is not met as evidenced by:	V 269		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary E Castro | TITLE: Administrator | (X6) DATE: 2/1/19

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-315	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED 01/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEILA'S MAGNOLIA PLACE	1619 FAIRFIELD DRIVE GASTONIA, NC 28054

(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
V 269	Continued From page 1 Based on interview the facility failed to ensure 1 of 1 client (#1) received services in the area licensed as "Community Respite Services." The findings are: Interview via phone on 1/16/19 with the Director revealed: - Facility placed client #1 as an emergency placement in the Community Respite Home; - Managed Care Organization (MCO) authorized client #1 to receive emergency placement services not Community Respite Services; - She would discuss the citation with her supervisor; - Client #1 had been discharged and was no longer residing at the facilty; - She was currently out of the office on sick leave; - Client #1's chart had been purged in her office and to delegate another staff to get the information would be a challenge therefore she would send client #1's treatment plan and date of discharge to the surveyor on 1/17/19 or 1/18/19, however the information was never received.	V 269		

Mary Corey

From: Mary Corey
Sent: Thursday, January 24, 2019 9:33 AM
To: 'Laura.Wallace@DHHS.NC.Gov'; 'Pridgen, Pam'
Cc: 'rmelton@partnersbhm.org'; 'susan.mcmickle@dhhs.nc.gov'; 'qm@partnersbhm.org'; Mary Corey
Subject: CONFIDENTIAL
Attachments: 20190117162749028.pdf

Good Morning,

I am sending this again to show that it was sent on January 17th as requested, but I see on the statement of deficiencies it states the below was not sent...please let me know if I have the incorrect email address for Laura Wallace.

Thanks,

Mary

Mary E. Costner, MA, EdS
Administrator
RHA Health Services, NC, LLC
1564-D Union Road, Gastonia NC 28054
Office 704-864-3450
Cell 704-813-4433
Fax 704-864-2347
mcorey@rhanet.org

-----Original Message-----
From: Mary Corey
Sent: Thursday, January 17, 2019 4:30 PM
To: 'Laura.Wallace@DHHS.NC.Gov' <Laura.Wallace@DHHS.NC.Gov>
Cc: Mary Corey <mcorey@rhanet.org>
Subject: CONFIDENTIAL

Hi Laura,

I have attached the updated plan for [redacted] while he was in placement at the Respite home, please let me know if you need anything else.

Mary

Mary E. Costner, MA, EdS
Administrator
RHA Health Services, NC, LLC
1564-D Union Road, Gastonia NC 28054
Office 704-864-3450
Cell 704-813-4433
Fax 704-864-2347
mcorey@rhanet.org

-----Original Message-----
From: do_not_reply-gastonia@rhanet.org [mailto:do_not_reply-gastonia@rhanet.org]
Sent: Thursday, January 17, 2019 4:28 PM
To: Mary Corey <mcorey@rhanet.org>
Subject: Message from "RNP002673BE7181"

WARNING: This email originated outside of RHA. DO NOT click links or attachments unless you recognize the sender and know the content is safe.

This E-mail was sent from "RNP002673BE7181" (MP 5054).

Scan Date: 01.17.2019 16:27:48 (-0500)
Queries to: do_not_reply-gastonia@rhanet.org

Name: [redacted] Date of Birth: [redacted] Record Number: [redacted]
Medicaid ID: [redacted] ISP Start Date: 12/1/2018

Update to Individual Support Plan

Meeting Date: 12/4/2018 Implementation Date: 12/1/2018

What is happening in my life right now?	**[redacted] was removed from RHA AFL care due investigation. RHA continues to provide Residential Services, but not in an AFL setting.**

What needs to change?	**[redacted] is in need of Residnetial Level 4 H2016HI to replace current authorized Residential Level 4 AFL H2016HI U2.**

Name: [redacted] **Date of Birth:** [redacted] **Record Number:** [redacted]
Medicaid ID: [redacted] **ISP Start Date: 12/1/2018**

My Action Plan

Goal 1:

- Who helps me: **RHA**/Support Staff
- How and How Often (service/frequency): **1 Units per Day/274 unts remaining for year.**
- **Where am I now? [redacted] is presently receiving Residential Supports 4: Individual to meet his personal care and habilitative needs.**
- **[redacted] continues to show baseline behaviors (which are outlined in the behavior plan and other parts of this plan), incontinence issues, defiance, resistance, and dangerous lack of awareness of surrounding or common hazards [redacted] needs have been met under a level 4, as it provides the detailed care and supervision needed for Tim on a 24-hour basis.**
- Where: **RHA** Residential Facility
- Target Date: 8/31/2019

Back-Up Staffing Plan		
Agency-Directed Services OR Individual/Family Direction / Agency With Choice (AWC) Model	**Who**	**Contact #**
Agency Back-Up (mandatory)	RHA, Appropriate QP	704-482-0560
Non-Paid Back-Up (in the event of an emergency)	NA	NA
Individual/Family Direction / Employer of Record (EOR) Model*	**Who**	**Contact #**
Back-Up Staffing Agency (Back-Up Staffing Agency must be included, even if EOR does not anticipate needing to use this agency)	**NA**	**NA**

Name: [redacted] Date of Birth: [redacted] Record Number: [redacted]
Medicaid ID: [redacted] ISP Start Date: 12/1/2018

Update to ISP Signature Pages

Statement of Concern or Disagreement

I, the individual/Legally Responsible Person signing this plan have concerns or disagree with the following issues related to my Individual Support Plan:

Individual and/or Legally Responsible Person Signatures

By signing this plan, I am indicating agreement with the bulleted statements listed here unless crossed through. I understand that I can cross through any statement with which I disagree.

- My Care Coordinator helped me know what services are available.
- I was informed of the range of providers in my community qualified to provide the service(s) included in my plan and freely chose the providers who will be providing services/supports.
- This plan includes the services/supports I need.
- I participated in the development of this plan.
- I understand that Partners Behavioral Health Management will be coordinating my care with the Partners Behavioral Health Management network providers listed in this plan.
- I understand that all services under the Innovations Waiver, including Residential Supports and Supported Living, should be requested to the full extent of the individual's level of medical necessity; regardless of the individual's budgeting category.
- I understand that services may be authorized in excess of the Individualized Budget.
- I agree to receive mail at the address included in my plan and understand that I am responsible for notifying my Care Coordinator and DSS of any address changes.

Signature of Individual [redacted] Date [redacted] 12/4/18

Signature of Legally Responsible Person Date

[signature] 12-4-2018

Signature of Care Coordinator Date

DocuSign Envelope ID: B2A97CB9-569F-4F3F-823B-7B2F33DA5E66

Name: [redacted] **Date of Birth:** [redacted] **Record Number:** [redacted]
Medicaid ID: [redacted] **ISP Start Date: 12/1/2018**

I acknowledge that I have received and reviewed the plan and attachments:

DocuSigned by:
Mary Costner, QP RHA Health Services LLC 12/4/2018 | 2:51 PM EST
FE63BB6F3E60409...

Signature of Qualified Professional / Agency Name	Date
Signature of Other Plan Participant /Agency Name	Date
Signature of Other Plan Participant / Agency Name	Date
Signature of Other Plan Participant / Agency Name	Date

February 1, 2019

Laura S. Wallace
Facility Compliance Consultant 1
Mental Health Licensure & Certification Section

RE: Survey attempted
Sheila's Magnolia Place
1619 Fairfield Drive, Gastonia NC 28054
MHL #036-315

Dear Ms. Wallace:

Please find the attached plan of correction for the deficiencies cited in your recent attempted survey by phone on December 11, 2018 of Sheila's Magnolia Place Respite Home, located at 1619 Fairfield Drive, Gastonia NC 28054. We thank you and your staff for your continued dedication to quality services. Please do not hesitate to call if you have any questions regarding plan of correction.

Regards,

Mary E Costner

Mary E. Costner
Administrator
RHA Health Services
1564-D Union Road
Gastonia NC 28054
704-864-3450