STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G211	A. BUILDING _____ B. WING _____	01/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GROUP HOME	928 MAGNOLIA DRIVE ABERDEEN, NC 28315

(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
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on record review and interview, 1 of 4 audit clients (#5) did not have a legal guardian appointed for her. The finding is: Client #5 did not have a legal guardian and needed one. During a review of client #5's record on 1/27/2020, it noted that she was admitted on 2/18/19. At that time, she did not have a legal guardian and the team noted she needed one appointed. A diagnosis of severe mental retardation was revealed as well as a need for assistance in choice making and decision making. Furthermore goal 8L revealed a restrictive behavior program with medications. Further review on 1/27/2020 revealed no legal guardianship paperwork. Interview with the qualified intellectual disability professional (QIDP) on 1/28/2020 revealed the mother is in the process of working with her own attorney to obtain legal guardianship of client #5. The facility stated they are not doing this for or with the guardian. They further indicated because they are an LLC if the facility assists in obtaining guardianship it will have to go through the facility attorney.	W 125	**W 125** **The facility will ensure the rights of all clients to make sure they exercise their rights. The QP will contact Client #5's Mother regarding her interest to become legal guardian. QP will provide assistance to the Mother if she agrees to become Client #5's legal guardian. QP will also review guardianship documentation for all clients to make sure the correct documentation is in their chart. The Team will monitor this matter during bi annual chart reviews.** DHSR - Mental Health FEB 24 2020 Lic. & Cert. Section	3-27-20

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

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 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.

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W 125	Continued From page 1 Further interview with the QIDP on 1/28/2020 confirmed client #5 does need a legal guardian appointed for her.	W 125		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facilty failed to assure staff utilized the gait vest for 1 of 4 audit clients (#3). The finding is: Client #3 was not assisted in ambulating by using the gait vest. Throughout observations both in the day program on 1/27/2020 and in the home on 1/28/2020, client #3 walked around without the assistance of staff. He was observed independently walking to his room from the living room and from the living room to the dining area among many more. Interview on 1/28/2020 during the observation of Staff A and later of Staff B revealed the gait vest should be held whenever he is up and walking. Staff B was asked well why do I see him walking around with nobody holding onto his vest? She	W 249	**W249** **The facility will ensure each client receives continuous active treatment. OT/PT Support Staff will in-service staff on making sure Client #3 receives assistance when ambulating with gait vest support from staff. The Team will monitor this during interaction assessments 2 times monthly.**	3-27-20

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W 249	Continued From page 2 indicated yes "sometimes they just get up and go and we watch them." Review of client #3's record on 1/28/2020 revealed "Fall prevention and Safety Guidelines" dated as "Revised 11/20/19." These guidelines noted, "Please use a gait vest to assist {Client #3] during navigation. If a gait vest is not available please use a gait belt." Interview on 1/28/2020, with the qualified intellectual disability professional (QIDP), confirmed client #3 should be assisted by staff holding onto the gait vest when he is walking.	W 249		
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to assure a technique to manage a behavior was incorporated into an active treatment program. This affected 1 of 4 audit clients (#3). The finding is: Client #3's use of the gait vest backward (restricting his ability to take it off independently) was not addressed by an active treatment plan. Throughout observations on 1/27/2020 and 1/28/2020, client #3 was seen walking around with the gait vest on backward. The zipper being in the back and the handle in the front.	W 288	**W288** **The Facility will ensure all inappropriate client behaviors are addressed formally through a Behavior Support Plan and reflected in the ISP. The Team will meet to discuss updating Client #3's ISP to address the need formally and update Client #3's ISP and BSP. The Team will monitor via bi-annually Chart reviews. QP to in-service staff on rights related to restrictive interventions and the Team will monitor through Interaction Assessments 2x's monthly.**	3-27-20

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W 288	Continued From page 3 Interview with staff A and Staff B on 1/27/2020 and 1/28/2020, revealed client #3 wears the gait belt backwards because he unzips the vest if it is on frontward. Review on 1/28/2020 of client #3's record revealed,"Fall prevention and Safety Guidelines" dated as "Revised 11/20/19." These guidelines noted, "Please use a gait vest to assist {Client #3] during navigation. If a gait vest is not available please use a gait belt. Can put the gait vest on backwards....secondary to increased attempts to remove." Additional review on 1/28/2020 revealed a behavior support program dated September 26, 2019. The program was a level II but did not address client #3's behavior of attempting to the gait vest off. Further interview with the qualified intellectual disability professional (QIDP) on 1/28/2020 confirmed the vest is on backward to keep client #3 from unzipping it. She further confirmed this means of managing the behavior is not incorporated into an active treatment plan to address the behavior.	W 288		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations and record reviews, the	W 369	**W369** **The Facility will ensure all drugs including those that are self-administered are administered without error, Nursing will in-service Client #4's medication administrator to ensure Client #4 receives all prescribed medications per physician orders. The Team will monitor with weekly medication observations.**	3-27-20

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W 369	Continued From page 4 facility failed to assure 2 of 26 observed medications were given without error. This affected 2 of 4 audit clients (#4 and #6). The findings are: 1. Client #4 did not receive her Polyeth Glyc Powder. During observations on 1/28/2020 of the morning medication pass at 7:00am, client #4 received Oyscal, Klor-con, Keppra, Enalapril, Cranberry, Tylenol. She did not receive Plyeth Glyc Powder. Review of client #4's current physician's orders dated 12/13/19 revealed she should also receive Polyeth Glyc POW 3350 NF for Gavilax to be given at 8am. Interview with the qualified intellectual disability professional (QIDP) and the nurse on 1/28/2020 confirmed the order is current and she should have received the Polyeth Glye Powder. 2. Client #6 did not receive her Flonase. During observations on 1/28/2020 of the morning medication pass at 8:00am, client #6 received Estradiol, Abilify, Buspar, Cranberry, Prozac, Intuniv, Lamictal and Omeprazole. She did not receive Flonase. Review of the most recent doctor's orders dated, 2/1/20-5/1/20 revealed an order for Flonase, one spray in each nostril daily (7am). Interview with the QIDP and the nurse on 1/28/2020 confirmed the order is current and she should have received Flonase during the morning medication pass.	W 369	**Nursing will in-service Client #6 medication administrator to ensure Client #6 receives all prescribed medications per physician orders. The Team will monitor with weekly medication observations.**	3-27-20

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NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

January 30,2020

Jonathan Bostic, Administrator
RHA HEALTH SERVICES, LLC
15235 Airport Rd.
Maxton, NC 28317

Re: Recertification Completed 1/28/2020
Magnolia Group Home, 925 Magnolia Dr., Aberdeen, NC 28315
Provider Number: 34G211
MHL#063012
E-mail Address: johnathan.bostic@rhanet.org

Dear Mr. Bostic:

Thank you for the cooperation and courtesy extended during the recertification survey completed 1/28/2020. This survey was required for continued participation in the Medicaid program.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form (CMS-2567). The purpose of the Statement of Deficiencies is to provide you with specific details of the practices that do not comply with regulations. You must develop one Plan of Correction that addresses each deficiency listed on the CMS-2567 form and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance and what to include in the Plan of Correction.

Type of Deficiencies Found

- Standard level deficiencies were cited.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is March 27, 2020.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the CMS-2567 Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Please be advised that additional W tags may be cited during the Life Safety Code portion of the recertification survey.

A follow up visit will be conducted to verify all deficient practices have been corrected. If we can be of further assistance, please call Joy Alford at 919-605-4336.

Sincerely,

Joy Alford

Joy Alford, QIDP/SW
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Enclosures

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