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 _____	07/18/2023

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 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who- This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure the qualified intellectual disabilities professional (QIDP) filed a death report with the State agency in a timely manner. This affected 1 of 1 former client (FC #6). The finding is: Record review on 7/18/23 of FC #6 hospital summary dated 7/12/23 revealed a chest x-ray found a significant amount of air under the diaphragm, aspiration pneumonia, that he continued to vomit and become less responsive. His date of death was on 7/13/23 at the hospital. Interview on 7/18/23 with the Quality Analysis (QA) Advisor revealed he started to prepare an Incident Response Improvement System (IRIS) report on 7/13/23 but had not completed it because he was waiting for the official death certificate. The QA stated he mentioned to the QIDP that she needed to file a death report with the State agency. The QA acknowledged the death certificate should be filed within 72 hours. Interview on 7/18/23 with the QIDP reveal she was aware of the FC #6's passing but did not file the death report with the State agency once he was discharged from the facility due to death.	W 159		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan,	W 249		

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 249	Continued From page 1 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 observation, record review and interview, the facility failed to ensure 1 of 4 audited clients (#1) received continuous active treatment program identified in the individual program plan (IPP) in the areas of physical therapy and fall prevention guidelines. The findings is: During afternoon observations on 7/17/23 at 5:09 PM client #1 walked to the kitchen with Staff A assisting with holding his hand to get a drink and walked client #1 to a seat in the activity room. Further observation revealed at 5:32pm -5:45pm Staff C held client #1 hand when assisting him to walk outside to sit on the porch. Staff C also held client #1's hand when assisting him in the house from the porch to the kitchen table. Review on 7/18/23 of client #1's Physical therapy evaluation dated 7/28/22 and Fall prevention guidelines dated 11/20/19 revealed - "Provide contact guard assistance/supervision by staff indoors and outdoors. This mean to keep [client #1] within your line of sight and keep hand contact on his gait belt during standing and walking." During interview on 7/18/23 the qualified intellectual developmental professional (QIDP)	W 249		

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W 249	Continued From page 2 confirmed that staff need to grip the gait belt with client #1 is ambulating.	W 249		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to follow diet orders as prescribed for 2 of 4 audit clients (#1 and #4). The findings are. A. During lunch observation at the vocational center on 7/17/23 at 10:45 AM, client #1 was observed eating a pureed lunch meat sandwich. Client #1 used a built up spoon to feed self and the sandwich looked "soupy" and dripped off the spoon. Staff B supervised client #1's meal. An additional observation of dinner in the home on 7/17/23 at 5:50 PM, Staff E processed baked chicken drumsticks in an appliance, adding a cup of water to blend. The chicken was softened, thick with a coarse texture that resembled "chunky tuna fish." Client #1 ate the mechanically softened chicken without incident. Further, client #1 signed for more food. Staff A assisted client #1 to serve himself more food, when Staff C stated he cannot have seconds. Staff A then took the food away from client #1. During breakfast on 7/18/23 at 7:30 AM, Staff D prepared cooked oatmeal for breakfast. The oatmeal was not processed with an appliance	W 460		

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W 460	Continued From page 3	W 460		

after cooking and still had a coarse texture. Client #1 was observed eating the oatmeal without incident.

Review on 7/18/23 of client #1's Nutritional evaluation dated 1/31/23 revealed, "Regular diet, puree consistency, honey thick liquids, ensure pudding or boost pudding 1 container TID. He may have seconds at each meal to help maintain healthy weight."

Interview on 7/18/23 with Staff A revealed she was unsure of client#1's diet.

B. During lunch observation at the vocational center on 7/17/23 at 10:45 AM, client #4 was observed eating a pureed lunch meat sandwich. Client #4's sandwich looked "soupy" and dripped off the spoon. An additional observation at dinner in the home on 7/17/23 at 5:50 PM revealed Staff E processed baked chicken drumsticks with an appliance, adding a cup of liquid to blend. The chicken was softened, thick with a coarse texture that resembled "chunky tuna fish." Client #4 ate the mechanically softened chicken without incident.

During breakfast on 7/18/23 at 7:30 AM, Staff D prepared cooked oatmeal for breakfast. The oatmeal was not processed with an appliance after cooking and still had a coarse texture. Client #4 was observed eating the oatmeal without incident.

Review on 7/17/23 of client #4's individual program plan (IPP) dated 10/25/22 revealed a 1500 calories weight loss diet with low concentrated sweets, puree consistency and thin liquids.

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W 460	Continued From page 4 Interview on 7/18/23 with the Home Manager (HM) revealed she knew clients #1 and #4 should have received a puree consistency. The HM compared their food to the other clients at the table and then went to speak with Staff D. The HM told Staff D that oatmeal had to be processed in the blender for pureed diets. Interview on 7/18/23 with the Administrator (ADM) revealed staff should be trained on dietary services before assigned to meal preparation. The ADM acknowledged that Staff D was a new hire and Staff E was a rehire and neither of them had received the dietary inservice the facility held in April, 2023. The ADM also acknowledged that more seasoned staff should have prepared the clients meals to ensure accuracy of diets.	W 460		
W 473	MEAL SERVICES CFR(s): 483.480(b)(2)(ii) Food must be served at appropriate temperature. This STANDARD is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure foods were served at appropriate temperatures. This had the potential to affect all clients (#1, #2, #3, #4 and #5). The finding is: During dinner observation in the home on 7/17/23 from 4:30 PM until 5:45 PM, baked chicken, cooked carrots and beans sat in pots and pans on the stovetop and counter. Staff E was preparing dinner and was observed de-boning the chicken drumsticks, then blended the meat in the food processor. Next, Staff E processed the carrots, dinner rolls and beans before all of the food was transferred to the dining room table to	W 473		

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W 473	Continued From page 5 be served. Staff E was not observed to reheat any of the food. All clients ate the food without incident. During breakfast observations in the home on 7/18/23 from 6:30 AM to 7:30 AM, Staff D preparing breakfast left a container of strawberry yogurt on the kitchen counter, that was not maintained cold. On the plates, clients were given apple sauce that was removed from a container. All clients ate the food without incident. Interview with Staff D on 7/18/23 revealed the food temperatures after she was asked by the surveyor to use a food thermometer to record it. The apple sauce was recorded at 82 degrees and the yogurt at 78 degrees. Staff D commented the applesauce was probably warm because it was placed next to the hot oatmeal. Interview with the Administrator revealed she did not know the food temperature range but staff should ensure that cold food is cold and hot food is served hot.	W 473		