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 ______	C 05/16/2024

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 000	INITIAL COMMENTS A complaint survey was completed on May 16, 2024 for intake #NC00216143. The allegation was substantiated with a deficiency cited.	W 000		
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 interviews, the facility failed to ensure adequate supervision for 1 of 2 audit clients (#3), to prevent injuries to others. The finding is: During observations in the home on 5/16/24 between 2:00-4:00pm, client #3 was observed with untrimmed finger nails on both hands. Client #3 returned from the day program at 2:00pm with Staff B walking by her side. Client #3 accompanied Staff B to the med room, where she was supervised while staff charted. At 3:05pm, client #3 walked out of the med room to go into the kitchen to look for snacks. After a minute, Staff B got up to follow client #3 into the kitchen. At 3:15pm, Staff A was on duty and took over providing 1:1 supervision for client #3. Record review on 5/16/24 revealed client #3's	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 249	Continued From page 1 Behavior Support Plan (BSP) from 5/8/24 aimed to decrease the frequency of defined target behaviors (physical aggression) to 0 incidents in 10 out of 12 consecutive months. Client #3 should have a responsible staff assigned to her at all times, during waking hours. Staff should monitor her whereabouts and establish visual contact every 10-15 minutes during sleep hours. In addition, a habilitation evaluation on 2/13/24 revealed client #3 pinched when agitated. A falls assessment from February 2023 recommended a clutter free environment. Record review on 5/16/24 revealed the following incidents: On 3/27/24 at 7:00pm, client #3 scratched client #4 on the left side of her neck while present in the dining room; two staff witnessed the incident. On 3/28/24 at 11:23am, client #3 lost her balance while getting out of bed and hit her face on a chair next to her bed. The injury to the right eye cause swelling and discoloration and she was evaluated and treated in the emergency room. On 4/8/24 at 2:30pm, client #3 scratched client #1 on the right side of his face, with two staff who witnessed the incident. At 8:00pm, client #3 dug her nails into client #2 while exiting the van; two staff witnessed the incident. Staff were advised to ensure clients were monitored at all times to prevent future reoccurrence of the same behavior. On 4/11/24 at 6:30pm, client #3 hit client #5 on the neck at the dinner table, who responded by punching client #3 in the arm. The incident was witnessed by two staff.	W 249		

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W 249	Continued From page 2 Interview on 5/15/24 with Staff A revealed when client #3 is agitated she will approach other clients to attack them. Interview on 5/15/24 with Staff B and Staff C revealed they are not trimming client #3's nails because she resists getting them filed or cut. Staff B revealed as the 1:1, she goes everywhere the client goes, but sometimes gets reports from client #1 that client #3 reached out and pinched him. Interview on 5/5/14 with the home manager revealed her last record on training staff on supervising client #3 occurred on 1/3/24. The home manager revealed on 3/28/24, client #3 fell into a folding chair kept in her bedroom, that has since been stored in the closet. Interview on 5/15/24 with the nurse revealed client had orders to have nails cut but she had not been allowing staff to trim nails. Interview on 5/15/24 with the qualified intellectual disabilities professional (QIDP) revealed client #3's family provided a shag throw rug when she moved to the facility two years ago. Overtime, the rug became worn and would need to be taped to the floor if they used it again. The QIDP revealed on 3/28/24, client #3 got up from her bed before lunch time, took a few steps and lost her balance and fell. The rug was on the floor and the chair was next to the bed, contributing to her injuries.	W 249		