STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
		B. WING	P WINC		
MHL049-175					01/10/2025
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT TH MAGNOLIA S		
SAFE HAV	/EN		SVILLE, NC 2811		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
V 000	INITIAL COMMENTS		V 000		
	An annual survey was Deficiencies were cite	s completed on 1/10/25. ed.			
	This facility is licensed f or the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.				
		d for 4 and currently has a ey sample consisted of ents.			
V 114	27G .0207 Emergenc	y Plans and Supplies	V 114		
	10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES  (a) Each facility shall develop a written fire plan and a disaster plan and shall make a copy of these plans available to the county emergency services agencies upon request. The plans shall include evacuation procedures and routes.  (b) The plans shall be made available to all staff				
	and evacuation proce posted in the facility.	dures and routes shall be			
	shall be held at least repeated for each shirt				
	simulate the facility's emergencies. (d) Each facility shall accessible for use.	response to fire			
	accessible for use.				

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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 (X3) A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		A. BOILDING.					
MHL049-175		B. WING		01/1	0/2025		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
SAFE HAV	/EN		I MAGNOLIA S				
	OLUMBA DV OT		ILLE, NC 2811				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 114	Continued From page 1		V 114				
	facility failed to hold fi quarterly for each shift Interview on 1/9/25 w revealed: -The first client was a 3/29/24; -Facility staff worked	ews and interviews, the ire and disaster drills ft. The findings are: with the Owner/Director					
	the months of April 20 revealed: -No documentation of quarter of April 2024 -No documentation of quarter of July 2024 -No documentation of	f a 3rd shift drill for the - June 2024; f a 3rd shift drill for the					
	drills for the months of 2024 revealed: -No documentation of 2024 - June 2024; -No documentation of quarter of July 2024 - No documentation of October 2024 - Decei	f drills for the quarter of mber 2024. vith Client #2 revealed:					
-He was admitted to the facility on 4/29/24; -Fire drills were held twice a month; -He was unable to remember a disaster drill.							

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Interview on 1/9/25 with Staff #1 revealed:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			R WING			
		MHL049-175	B. WING		01/10/2025	
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA			
SAFE HAV	/EN		H MAGNOLIA S ILLE, NC 2811			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETE	
V 114	Continued From page	2	V 114			
	14 Continued From page 2  -He had been employed at the facility since the first client was admitted in March 2024; -Fire drills were held on the 1st and 15th of every month; -He primarily worked 2nd shift so he was not aware if fire drills were held on 3rd shift; -Disaster drills were not consistently completed"We try to do those twice a month. That's sporadic." -He was unable to remember when the last disaster drill was completed or what type of drill it was.  Additional interview on 1/9/25 with the Owner/Director revealed: -Fire and disaster drills were completed at the same time; -He was going to ensure disaster drills were documented; -He was not aware drills were required to be completed on each shift; -"I don't think many (drills) have been done on 3rd shift."					
V 118	27G .0209 (C) Medica	ation Requirements	V 118			
	only be administered order of a person autidrugs. (2) Medications shall clients only when auticlient's physician. (3) Medications, incluadministered only by					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	I DENTI I DATION NOMBER.		A. BUILDING: _			
		MHL049-175	B. WING		01/1	0/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE		
SAFE HAV	VEN		H MAGNOLIA S /ILLE, NC 2811			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	DN	(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	COMPLETE DATE
V 118	Continued From page	÷ 3	V 118			
	pharmacist or other le privileged to prepare (4) A Medication Adm all drugs administered current. Medications a recorded immediately MAR is to include the (A) client's name; (B) name, strength, a (C) instructions for ac (D) date and time the (E) name or initials of drug. (5) Client requests for checks shall be recordinated.	egally qualified person and and administer medications. inistration Record (MAR) of d to each client must be kept administered shall be after administration. The following:				
	administration for 2 of #2). The findings are:  Review on 1/9/25 of 0-An admission date of -An age of 13 years of -Diagnoses included All Hyperactivity Disorder Traumatic Stress Disorder A Physician Order da Hydrochlorothiazide (	ews, interviews and ty failed to document IARs immediately after f 3 audited clients (#1 and Client #1's record revealed: f 3/18/24; old; Attention Deficit r (ADHD) and Post				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
MHL049-175		B. WING	B. WING		
<b>'</b>			DDRESS, CITY, STA	TE. ZIP CODE	01/10/2025
			TH MAGNOLIA S		
SAFE HAV	/EN	MOORES	VILLE, NC 2811	15	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 118	Continued From page	e 4	V 118		
	Quetiapine Fumarate (regulate mood) 100mg, take 1 and a half tablets po daily at 6:45am, and Clonidine HCL (ADHD) 0.1mg, take 1 po at 7:00am.  Review on 1/9/25 of Client #1's MARs for the month of January 2025 revealed: -No documentation at 12:30pm that Hydroxyzine HCL, Quetiapine Fumarate and Clonidine had been administered that morning.  Interview on 1/9/25 with Client #1 revealed: -Staff #2 had administered him his morning medications earlier in the day.  Review on 1/9/25 of Client #2's record revealed: -An admission date of 4/29/24; -An age of 16 years old; -Diagnoses included ADHD, PTSD, Disruptive Mood Dysregulation Disorder, and Mild Intellectual Developmental Disability; -A physician order dated 9/16/24 for Clonidine HCL (ADHD) .1mg, take 1 tablet daily at 7:00am.				
	month of January 202	12:03pm that Clonidine had			
		ith Client #2 revealed: tered him his morning he day.			
	Observation on 1/9/25 at 1:25pm of Staff #2 revealed: -Staff #2 documented her initials on the MARs for Clients #1 and #2 which indicated that she had administered their morning medications for the day.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
MHL049-175		B. WING		01/	01/10/2025	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
SAFE HA	VEN		H MAGNOLIA S VILLE, NC 2811			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
V 118	Interview on 1/9/25 w -She had been emploat the facility since Ma -She had been trained Administration; -She had administered and #2 earlier in the case. The failed to docume and administered means admin	ith Staff #2 revealed: yed as a Paraprofessional ay 2024; d in Medication  d medications to Clients #1 day; ent on the MARs that she dications; at the MARs). We (staff and this morningNormally, it's  ith the Owner/Director ring a telephone call earlier 2 she failed to document the and #2 after she	V 118			

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