DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 ______	R 11/10/2025

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 revisit was conducted on 11/10/25 for deficiencies cited on 8/25 - 8/26/25. Two deficiencies were recited and one new deficiency was also cited. The facility remains out of compliance.	W 000		
{W 227}	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure client #6's Individual Program Plan (IPP) included objectives to address client #6's needs. This affected 1 of 3 audit clients. The findings are: A. Interview on 8/25/25 with Staff A revealed client #6 performs tasks at the day program such as cleaning light switches and door knobs. Additional interview indicated client #6 is paid for performing these work tasks. Review on 8/25/25 of client #6's IPP dated 12/10/24 revealed, "[Client #6] understands the concept of purchasing and saving and relationship between money and purchasing." Additional review of the client's Adaptive Behavior Inventory (ABI) last reviewed 2/3/25 noted various strengths in the area of money management including identifying money, stating the equivalency of money, and some budgeting skills. Further review of the ABI included no assessment of his ability to count money combinations and to count change.	{W 227}		

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 227}	Continued From page 1 Interview on 8/26/25 with the Home Manager (HM) indicated the client carries a wallet with him every where and can identify coins, bills and wait for change. Additional interview noted some aspects of the ABI; however, may be incorrect concerning his abilities in this area. Interview on 8/26/25 with the Qualified Intellectual Disabilities Professional (QIDP) acknowledged client #6 has not reached his potential in the area of money management and more training may be necessary. B. During observations of medication administration in the home on 8/26/25 at 7:40am, the Medication Technician (MT) completed the majority of tasks while client #6 attempted to punch one pill card and consumed his medications. Client #6 was not prompted or assisted to complete any other tasks during the administration of his medications. Review on 8/26/25 of client #6's IPP dated 12/10/24 revealed he had worked on an objective to identify the side effects of two of his medications with 90% accuracy for 3 consecutive review periods. The plan indicated the objective had been discontinued on 10/18/24. Additional review of the IPP did not include any further training in the area of medication administration. Interview on 8/26/25 with the HM indicated client #6 has had some training regarding the administration of his medications; however, no recent training has been implemented. Interview on 8/26/25 with the former QIDP confirmed client #6 had trained on an objective	{W 227}		

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{W 227}	Continued From page 2 for the administration of his medications; however, no further training had been implemented after the previous objective was discontinued. The QIDP acknowledged client #6 continues to have needs in this area. During a follow-up on 11/10/25, review of client #6's IPP dated 12/10/24 revealed objectives to complete laundry tasks, use a Swiffer mop and toothbrushing. Additional review of the IPP did not include objectives to address his money management and medication administration needs. Interview on 11/10/25 with the QIDP confirmed no new objectives had been implemented in the area of money management or medication administration for client #6.	{W 227}		
{W 368}	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #1 received her medications in accordance to physician's orders. This affected 1 of 3 clients observed receiving medications. The findings are: A. During observations of medication administration in the home on 8/26/25 at 6:56am, client #1 was administered one spray of Flonase 50mcg to both nostrils. Review on 8/26/25 of client #1's most current physician's orders revealed an order for Flonase	{W 368}		

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{W 368}	Continued From page 3 50mcg, "use two sprays in each nostril" once every day at 8am. Interview on 8/26/25 with the facility nurse confirmed client #1's physician's orders were current and should be followed as written. B. During observations of medication administration in the home on 8/26/25 at 6:56am, the Medication Technician (MT) poured an undetermined amount of Chlorhex solution .12% into the bottle cap then into a medication cup and gave it to client #1. The client proceeded to take the liquid into the bathroom (spilling some of it along the way), put it into her mouth and immediately spit it into the sink. The client was not prompted to rinse her mouth with the solution. Immediate interview with the MT indicated client #1 should rinse her mouth with the solution. Review on 8/26/25 of client #1's current physician's orders revealed an order for Chlorhex solution .12%, "swish 10ml in mouth for 30 seconds" and spit solution out twice daily at 8am and 8pm. Interview on 8/26/25 with the facility nurse confirmed client #1's physician's orders were current and she should swish with 10ml of the solution for 30 seconds as indicated. During a follow-up on 11/10/25, observations of medication administration in the home on 11/10/25 at 7:50am, client #5 injested twelve medications. In addition, the MT poured 10cc of Listerine mouthwash into pill cup, presented it to client #5 and prompted the client to "swish" it in her mouth. Client #5 took the mouthwash and	{W 368}		

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{W 368}	Continued From page 4 drank it. The MT stated, "You always drink it." No further attempts were made to ensure the client's mouthwash was administered appropriately. Review on 11/10/25 of client #5's most current physician's orders noted an order for Listerine Cool Mint, "brush teeth/gumline twice daily for plaque" at 7am/8pm. Interview with the facility nurse confirmed client #5's teeth and gums should have been brushed with the mouthwash as indicated on her physician's orders. The nurse indicated the client does not understand how to "swish" liquids in her mouth.	{W 368}		
W 468	MEAL SERVICES CFR(s): 483.480(b)(1) Each client must receive meals at regular times comparable to normal mealtimes in the community. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure clients received their meals at normal mealtimes. This affected 4 of 6 clients (#2, #3, #4 and #5) residing in the home. The finding is: Upon arrival to the home on 11/10/25 at 6:10am, client #4 was seated at the dining room table eating a bowl of cereal. Client #2 and #3 were in their rooms in the bed while client #5 was in a recliner in the living room. Immediate interview with client #4 revealed this was her breakfast meal and three other clients (#2, #3 and #5) had already eaten breakfast that morning which only consisted of cereal as well.	W 468		

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W 468	Continued From page 5 Interview on 11/10/24 with Staff A indicated client #4 usually likes cereal for breakfast. Additional interview with Staff B noted breakfast is normally served before first shift arrives. Interview on 11/10/24 with the Home Manager (HM) indicated breakfast is usually served at 6:30am and clients should not be eating before then.	W 468		