STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL035-078	A. BUILDING: _____ B. WING _____	06/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY GROUP HOME #1	663 MOULTON ROAD LOUISBURG, NC 27549

(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) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and complaint survey was completed on 6/3/22. Complaint #NC00188027 was unsubstantiated. Complaint #NC00188758 was substantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 5 and currently has a census of 3. The survey sample consisted of audits of 3 current clients and 1 former client. A sister facility is identified in this report. The sister facility will be identified as sister facility C.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained	V 108	DHSR - Mental Health JUN 27 2022 Lic. & Cert. Section	

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V 108	Continued From page 1 to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that staff were currently trained in CPR (Cardiopulmonary Resuscitation)/First Aid for 1 of 1 current staff (#5) and 1 of 1 former staff (FS #6). The findings are: Review on 5/24/22 of staff #5's record revealed: - Was re-hired on 12/27/21 - Title: Direct Support Professional - CPR/First Aid certificate expired 10/2021 Review on 5/24/22 of FS #6's record revealed: - Hired: 1/1/21 - Resigned: 4/27/22 - Title: House Manager - CPR/First Aid certification expired 1/2022 Interview on 5/25/22 FS #6 reported: - She was behind on her CPR/First Aid prior to her resigning from the company. - She worked alone on her shift. Interview on 5/24/22 the Executive Director	V 108		

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FRANKLIN COUNTY GROUP HOME #1	663 MOULTON ROAD LOUISBURG, NC 27549

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V 108	Continued From page 2 reported: - She went over a list of trainings in their monthly meetings. - Staff had missed some trainings due to lack of staffing. - It's the house manager's responsibility to schedule trainings. - There was no house manager at this facility. - They were starting to get the trainings done although some were late.	V 108		
V 121	27G .0209 (F) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure psychotropic drug regimen reviews were completed for 2 of 3 audited clients (#1, #3). The findings are: Review on 5/25/22 of Client #1's record revealed:	V 121		

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FRANKLIN COUNTY GROUP HOME #1	663 MOULTON ROAD LOUISBURG, NC 27549

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V 121	Continued From page 3 - Admitted: 5/6/08 - Diagnoses: Rule out Depressive disorder (d/o), Moderate Intellectual Disability, Unspecified Anxiety d/o and Unspecified Bipolar d/o - FL2 dated 1/5/21 revealed: - Aripiprazole 10 milligram (mg) tablet (tab) (depression) - Divalproex 250 mg (bipolar) - FL2 dated 1/6/22 revealed: - Aripiprazole 5 mg tab - Divalproex 250 mg - Last drug regimen review completed 6/1/21 Review on 5/25/22 of Client #3's record revealed: - Admitted: 7/17/06 - Diagnoses: Psychotic d/o, Severe Intellectual Developmental d/o and Moderate Mental Retardation - FL2 dated 1/13/21 revealed: - Benztropine Mes 2 mg tab (involuntary movements) - Perphenazine 4mg tab (schizophrenia) - FL2 dated 1/14/22 revealed: - Benztropine Mes 2 mg tab - Perphenazine 4mg tab - Last drug regimen review completed 6/1/21 Interview on 5/25/22 the Executive Director reported: - She "believed" they were behind on having medication reviews - Called the pharmacy this morning, 5/25/22, to see if they had another review on file and was told they didn't - The pharmacist was in the process of doing a review now to get them on schedule	V 121		
V 290	27G .5602 Supervised Living - Staff	V 290		

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V 290	Continued From page 4 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of	V 290		

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V 290	Continued From page 5 secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure a minimum number of staff present to supervise 3 of 3 audited clients (#1, #2 & #3). The findings are: Review on 5/25/22 of client #1's record revealed: - Admitted: 5/6/08 - Diagnoses: Rule-Out Depressive disorder and Moderate Intellectual Disability Review on 5/25/22 of client #2's record revealed: - Admitted: 7/10/78 - Diagnosis: Moderate Intellectual Developmental disability Review on 5/25/22 of client #3's record revealed: - Admitted: 7/10/06 - Diagnoses: Psychotic Disorder, NOS (None otherwise specified), Severe Intellectual Developmental disorder and Moderate Mental Retardation Interview on 5/25/22 staff #5 reported: - She worked as a Direct Care Professional - Worked 2nd shift, 3pm - 11pm but had been helping out with the mornings and transportation of the clients to and from day programs - Clients attend the day program everyday except Friday. - The clients went to Sister Facility C on Friday,	V 290		

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V 290	Continued From page 6 5/20/22, because she had medication training. - Client #3 had COVID back in February 2022 and then FS (Former Staff) #6 caught it so the clients went to Sister Facility C for that day because there was no staff available. - "Can't leave the clients by themselves." Interview on 6/2/22 FS #6 reported: - These client's were dropped off at Sister Facility C several times. - She and another staff were out for a few days back in February 2022 and the clients went to Sister Facility C until they were picked up by the weekend person that evening. - The clients were dropped off at Sister Facility C every day the week she was out sick in February. - The home manager would be the only staff at Sister Facility C with her clients as well as the clients that were dropped off. Interview on 5/25/22 the Executive Director stated: - Been struggling over the last few months maintaining staff. - The home manager left and they hadn't found a replacement yet. - She had been helping out in the facility since the home manager left.	V 290		

Plan of Correction – FCGH # 1

Date of Correction: August 2, 2022

Deficiency Cited: V108: 27G.0202 Personnel Requirements. Based on record review and interviews the facility failed to ensure one of three audited staff's training in CPR/FA were current.

Provider's Plan of Correction: Legacy Human Services, Inc. will assure that each staff member is current and up to date with their required trainings. Monthly at the Quality Management Team meeting, managers will be given a list of staff needing training, and they will mandate that staff attend necessary training. Staff whose training expires, will be taken off the schedule. The Executive Director will assure that trainings are scheduled routinely.

Responsible Parties: Residential Manager, QP, Human Resources, and Executive Director

Correction Date: 8/2/2022

Deficiency Cited: V121: 10A NCAC 27G.0209. Medication Requirements. If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months.

Provider's Plan of Correction: Legacy Human Services, Inc. will assure that each facility shall have a scheduled Medication Review by the pharmacist at Medical Arts Pharmacy. These are scheduled March, June, September, and December. Pharmacy reviews will be monitored by the clinical staff and filed by residential managers. Completing four per year, will assure that standard is met and exceeded.

Responsible Parties: Residential Manager, RN, QP, Quality Improvement Committee, and Executive Director

Correction Date: 6/8/2022

Deficiency Cited: V290: 27G.05602. Supervised Living - Staff. Based on record review and interview the facility failed to ensure a minimum number of staff present to supervise tow of three audited clients.

Provider's Plan of Correction: Legacy Human Services, Inc. will assure that each facility is adequately staffed such that residents are able to receive services in their own facility without having to be supervised in another facility due to staff shortages, COVID outbreaks, or disruptions in day placements. Legacy accepts the responsibility of providing the staffing at

whatever extent necessary so that residents experience continuity and consistency. This will be accomplished by utilizing the clinical on call system to provide staffing when the home does not have Direct Support Professionals available. Clients will not be allowed to sleepover at other licensed facilities.

Responsible Parties: Residential Manager, On Call salaried employees, and Executive Director

Correction Date: 6/8/2022

Provider Signature: 

Legacy Human Services, Inc.

626 S. Garnett Street
P.O. Box 88
Henderson, NC 27536
252-438-6700 Office
252-438-6720 Fax

June 21, 2022

Mental Health Licensure and Certification Section

NC Division of Health Service Regulation

2718 Mail Service Center

Raleigh, NC 27699-2718

Dear Sir/Madam,

Please find enclosed the plan of correction for the standard level deficiencies cited at the Franklin County Group Home # 1, Located at 663 Moulton Road, Louisburg, NC 27549. This is in conjunction with MHL #: 035-078.

You shall find upon return that the deficiencies cited have been addressed globally and the correction has been made prior to the correction date of August 2, 2022. Should you have any questions or concerns, please do not hesitate to contact me at the number provided. We thank you for your feedback, and welcome your return.

Sincerely,

[redacted]

Executive Director

ASPIRE to Excellence® carf ACCREDITED

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

6/21/22

[redacted]
Legacy Human Services, Inc.
P.O. Box 88
Henderson, NC 27536

Re: Annual and Complaint Survey completed 6/3/22
Franklin County Group Home #1, 663 Moulton Rd., Louisburg, NC 27549
MHL # 035-078
E-mail Address: jjohnson@legacyhumanservices.org
Intake #'s NC00188758 & NC00188027

Dear Ms. Johnson:

Thank you for the cooperation and courtesy extended during the annual & complaint survey completed 6-3-22. Complaint #NC00188027 was unsubstantiated and #NC00188758 was substantiated.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State 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 plus what to include in the Plan of Correction.

Type of Deficiencies Found

- All other tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is 8/2/22.

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 State 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 & CERTIFICATION SECTION

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION

LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603
MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718
www.ncdhhs.gov/dhsr • TEL: 919-855-3795 • FAX: 919-715-8078

6/21/22
Ms. Johnson
Legacy Human Services, Inc.

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

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Renee Kowalski at 919-552-6847.

Sincerely,

Tinika Ferguson, MSW
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: DHSR@Alliancebhc.org
QM@partnersbhm.org
dhhs@vayahealth.com
DHSRreports@eastpointe.net
Joy Futrell, CEO, Trillium Health Resources LME/MCO
Fonda Gonzales, Director of Quality Management, Trillium Health Resources LME/MCO
Pam Pridgen, Administrative Supervisor