STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 follow up survey was completed on January 31, 2024. 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 6 and currently has a census of 6. The survey sample consisted of audits of 3 current clients.	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 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.	V 108	RECEIVED FEB 26 2024 DHSR-MH Licensure Sect	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 108	Continued From page 1 (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 3 of 3 audited paraprofessional staff (#1, #2 & Residential Manager) and 1 of 1 Qualified Professional (QP) had training to meet mh/dd/sa needs of the client. The findings are: Review on 1/24/24 of staff #1's personnel record revealed: - Hired 6/8/23 - No documentation for suicide awareness and prevention training Review on 1/24/24 of staff #2's personnel record revealed: - Hired 9/16/20 - No documentation for suicide awareness and prevention training Review on 1/24/24 of the Residential Manager's personnel record revealed: - Hired 1/1/21 - No documentation for suicide awareness and prevention training Review on 1/25/24 of the QP's personnel record revealed: - Hired 3/10/14 - No documentation for suicide awareness and	V 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 108	Continued From page 2 prevention training Interview on 1/24/24 staff #1 reported: - Was "pretty sure" she had training in suicide awareness and prevention - Client #6 was "very depressed" and attempted suicide on 9/27/23 - Knew to report "anything other than his (client #6) normal self" to the Residential Manager Interview on 1/24/24 staff #2 reported: - Client #6 attempted suicide on 9/27/23 - Hadn't had training in suicide awareness and prevention - Knew that "you can tell by looking at a person" if they were acting outside of their normal behavior Interview on 1/29/24 the Cardiopulmonary Resuscitation (CPR) Instructor reported: - Suicide awareness and prevention was not covered in the CPR and first aid curriculum Interview on 1/29/24 the Registered Nurse (RN) reported: - Was a nurse consultant for the facility - Was responsible for conducting medication administration training in the facility - She spoke with the Executive Director and provided the facility a suicide awareness and prevention training guide last week - She planned to train staff on suicide awareness and prevention "soon" Interview on 1/24/24 the Residential Manager reported: - Client #6 eloped on 7/13/23 and was involuntarily committed at a local hospital for thoughts of suicidal ideation - Client #6 attempted suicide on 9/27/23	V 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 108	Continued From page 3 - "Never" received training on suicide awareness and prevention - "Will probably have to get the nurse (RN) to do a training" Interview on 1/30/24 the QP reported: - Responsible for "trainings that will help improve staff and clients knowledge" in the facility - Hadn't received training in suicide awareness and prevention - "Suicide training is outside of my scope" - A therapist was responsible for training staff in suicide awareness and prevention, but "I don't know, I could be wrong" - Didn't contact a therapist to coordinate suicide awareness and prevention training because "It (client #6's suicide attempt) was a one time thing" Interviews on 1/24/24 and 1/31/24 the Executive Director reported: - Client #6 was Legacy Human Service LLC's (Licensee) first client to attempt suicide - Didn't have a training for suicide awareness and prevention - Suicide awareness and prevention was covered in CPR and First Aid - The agency didn't have anyone to conduct a training on suicide awareness and prevention - Planned to try to locate someone to conduct the suicide awareness and prevention training This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 violation and must be corrected within 23 days.	V 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 109	Continued From page 4	V 109		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter.	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 109	Continued From page 5	V 109		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure 1 of 1 Qualified Professional (QP) demonstrated the knowledge, skills and abilities required by the population served. The findings are:

A. Cross reference: 10A NCAC 27G .0202 Personnel Requirements (V108). Based on record review and interview, the facility failed to ensure 3 of 3 audited paraprofessional staff (#1, #2 & Residential Manager) and 1 of 1 Qualified Professional (QP) had training to meet mh/dd/sa needs of the client.

B. Cross reference: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112). Based on record review and interview, the facility failed to develop and implement strategies to address 1 of 3 audited client's needs (#6).

C. Cross reference: GS 122C-62. Additional Rights in 24-Hour Facilities (V364). Based on record review and interview, the facility failed to ensure the restriction of 1 of 3 client's (#6) access to person property had a written statement detailing the reason for the restriction and failed to review the restriction as required.

Review on 1/25/24 of the QP's personnel record revealed:
- A signed job description dated 4/6/21:
- "Assess training needs, coordinate the orientation training and on-going and in-going service training for direct care staff"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 109	Continued From page 6 - "Ensure that all services, programming, treatment plans and required documentation are developed and implemented accurately and on a timely basis." - "Educate staff and enforce the individuals' rights and services." Review on 1/31/24 of a Plan of Protection dated 1/31/24 and written by the Executive Director/QP revealed: "1) As of today, within 23 days, the team of Legacy Human Services (Licensee) will schedule a meeting with the guardian to discuss, plan, and determine a plan of action for their requested restrictions of [client #6's initials]'s electronics. 2) As of today, within 23 days, the team will search for a credable clinician to provide suicide awareness and prevention training for staff. 3) As of today, the PCP (Person Centered Plan) will be updated within 23 days to reflect the changes and new steps to address [client #6's initials]'s needs. #4) As of today, within the next 23 days, the Executive Director will seek and provide additional training to the Q.P. regarding clinical competencies. Describe your plans to make sure the above happens. -The Executive Director/QP will schedule the team meeting to discuss #1. -The Executive Director/QP will seek a credible clinician to teach suicide awareness and prevention. -The Executive Director/QP will facilitate a revised PCP for [client #6's initials]. -The E.D. (Executive Director)/QP will facilitate additional QP training." Client #6 had diagnoses of Mild Intellectual Developmental Disorder, Autism Spectrum Disorder Asperger's, Persistent Depressive Disorder, and Posttraumatic Stress Disorder. Client #6 had history of thoughts of suicidal ideation and threats of suicide. Client #6 was	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 109	Continued From page 7 involuntary committed on 7/13/23 for thoughts of suicidal ideation. Client #6 attempted suicide on 9/27/23. The QP did not train staff nor coordinate with a qualified instructor to train staff on suicide awareness and prevention. The QP was responsible for developing and updating client #6's treatment plan. There were no goals and strategies to address client #6's verbal threats of suicide or attempted suicide. Client #6's treatment plan did not include strategies to decrease thoughts of suicidal ideation and threats of suicide, or structure the use of client #6's electronics. Also, client #6's treatment plan was not updated to include strategies to prevent cheeking medications. Client #6 was required to turn in his game system and IPad to staff at 9pm every night. This restriction on his rights did not have a written statement detailing the reason nor was it reviewed every 7 days. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 109		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible;	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 112	Continued From page 8 (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop and implement goals and strategies to address 1 of 3 audited client's needs (#6). The findings are: Review on 1/23/24 of client #6's record revealed: - Admitted 1/24/20 - Diagnoses of Mild Intellectual Developmental Disorder, Autism Spectrum Disorder (Asperger's), Persistent Depressive Disorder, Posttraumatic Stress Disorder (PTSD), and Gender Dysphoria - A Psychological Evaluation with the latest date of evaluation listed as 2/13/18: "Suicide threats and behaviors occur after he (client #6) gets upset when he does not get his way...His biological mother...reportedly blamed him for things...He stills idealizes her and seems to follow suit in self-blame when he is upset, which then results in self-harm and/or suicidal ideations." - A progress note dated 1/3/24: "[Client #6] ran	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 112	Continued From page 9 away from the group home on 7-13th-2023...was taking to the Hospital on that day for PTSD and Suicide and Anxiety feelings to [Local Hospital] for 7 days...he (client #6) went to the Hospital on September 28th 2023 for Suicide Attempt..." - A treatment plan dated 9/19/23: "In the past he tried to harm himself close monitoring is required." - The treatment plan didn't contain goals or strategies for: - Thoughts of suicidal ideation and threats of suicide - Structured use of electronics - No updated treatment plan to address his suicide attempt on 9/27/23 Review on 1/24/24 of the facility's records revealed: - Client #6's After Visit Hospital Summary dated 7/20/23: "You (client #6) were admitted to [Local Hospital Behavioral Health] for symptoms of suicidal thoughts..." Interview on 1/24/24 client #6 reported: - Had goals to clean the house and exercise - Had more goals but could not recall them - Was "depressed" and "not wanting to be alive anymore" - "Been thinking about it (suicide) all my life" - Cut his arm with broken glass and eloped on 7/13/23 - "Went to the hospital because I had thoughts to kill myself" on 7/13/23 - Attempted suicide 9/27/23 - Overdosed on his Lithium pills - "Held it (Lithium pills) in my mouth between my teeth" after receiving his medications - Been "cheeking" his Lithium pills for "months" - After 9/27/23, staff monitored him for "cheeking" medication by checking his "whole	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 112	Continued From page 10 mouth" including "under my tongue" and he "drinks extra water" after his medications were administered to him - Staff searched his bedroom "once a week" - Had to give staff his electronics (game system and IPad) at 9pm every night "so I won't stay up late" Interview on 1/24/24 staff #1 reported: - Received "basic training of everyone's (clients') behavior and changes and more specific training with [client #6]" - Knew client #6 was "very depressed" - Close monitoring in client #6's treatment plan meant client #6 "can't be alone" - Didn't know how often she needed to check on client #6, but she "checked on them (clients) every 15 minutes anyway" Interview on 1/24/24 staff #2 reported: - Close monitoring in client #6's treatment plan meant to check on client #6 "every two hours" to "see he's doing good" - Knew client #6 had thoughts of suicidal ideation and made threats of suicide - Client #6 would say "I want to kill myself when he's upset" - Knew to give client #6 his PRN (as needed) medication of Hydroxyzine 25 milligrams (mg) when he became upset Interview on 1/30/24 client #6's Psychiatrist reported: - First visit with client #6 was 10/7/19 - Client #6 had a "long term history" of self-harm, thoughts of suicidal ideation, and threats of suicide - Client #6 made comments such as "I don't feel right...I don't feel good..or I think about killing myself" when he became "upset about	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 112	Continued From page 11 something" - Client #6 was involuntarily committed into hospitals several times due to thoughts of suicidal ideation and threats of suicide - Client #6 "would have thoughts on it but hadn't ever acted" until 9/27/23 Attempted interviews on 1/31/24 with client #6's therapist were unsuccessful because she had retired and had not returned the phone calls prior to exit of the survey. Interviews on 1/23/24 and 1/24/24 the Residential Manager reported: - Client #6 would express thoughts of suicidal ideation, but "not often" - Client #6 would say "I feel like I want to kill myself" - If client #6 expressed thoughts of suicidal ideation, staff would administer him his PRN medication of Hydroxyzine 25mg - On 7/13/23, client #6 became upset when staff attempted to wake him up to get ready to go to the day program - As a result of becoming upset, client #6 eloped from the facility and was missing for 16-18 hours - When client #6 was located, he expressed thoughts of suicidal ideation and was involuntarily committed at a local hospital for a week - After the 7/13/23 incident, the treatment team agreed to limit client #6's use of electronics at night because client #6 would "stay up all night" playing his game and didn't want to get up in the mornings - Client #6 attempted suicide on 9/27/23 by crushing and ingesting his Lithium pills - Client #6 admitted to "cheeking" his Lithium pills and saving them in a container that was kept hidden in his bedroom	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 112	Continued From page 12 - After 9/27/23, staff "take extra steps" when administering client #6 his medication to ensure he's doesn't "cheek" his medicine and staff conducted a weekly room search - Close monitoring meant having a "staff in the home" - There wasn't a specified time to check client #6, but "I would say every 30 minutes to an hour" Interview on 1/30/24 the QP reported: - Was responsible for developing the clients' treatment plans - Treatment plans were developed "once a year" and "updated" as needed - The strategies used for client #6 to prevent "cheeking" medications, to structure the use of his electronics, and decrease thoughts of suicidal ideation and threats of suicide were supposed to be in client #6's treatment plan but "I haven't included it in the PCP (person centered plan) yet" - "I mainly deal with goals in independent living" or clients "may have a social goal" - Client #6 didn't have a behavior support plan (BSP) so therefore client #6 didn't have any behavioral goals - There were no goals to address client #6's thoughts of suicidal ideation or threats of suicide because he had to "go through a psychiatrist to get a goal" or "have him suggest to put one (a goal) in place" - Didn't contact the psychiatrist to develop a goal for client #6 because client #6 "never" attempted suicide before Interview on 1/31/24 the Executive Director revealed: - The QP was responsible for developing and updating clients' treatment plans - Treatment plans were updated if there was a "significant change for a person (client)"	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 112	Continued From page 13 - Was unaware client #6's treatment plan didn't include the strategies to decrease thoughts of suicidal ideation and threats of suicide, or structure the use of client #6's electronics - Was unaware client #6's treament plan was not updated to include the strategies to prevent him from "cheeking" medications - "All of the services that are provided (to client #6) should be listed" in client #6's treatment plan - Client #6 was unable to receive a BSP due to "funding;" therefore, client #6 didn't have any "behavioral" goals for thoughts of suicidal ideation and threats of suicide - Legacy Human Services, LLC (Licensee) didn't have a psychologist to develop goals for thoughts of suicidal ideation and threats of suicide - Client #6 "never had a plan (BSP) for suicide because he (client #6) never had suicidal behavior" - Was never informed by client #6's guardian that client #6 made threats of suicide or had any attempts of suicide - Could not recall when she received client #6's psychological evaluation - "Not sure" what close monitoring meant because "I didn't write it...you can ask [QP]" This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 violation and must be corrected within 23 days.	V 112		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 113	Continued From page 14 contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143.	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 113	Continued From page 15	V 113		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure 1 of 3 audited client's (#6) record contained full documentation of services provided and progress towards the outcomes. The findings are:

Review on 1/23/24 of client #6's record revealed:
- Admitted 1/24/2020
- Diagnoses of Mild Intellectual Developmental Disorder, Autism Spectrum Disorder (Asperger's), Persistent Depressive Disorder, Posttraumatic Stress Disorder (PTSD), and Gender Dysphoria
- July - December 2023 progress notes all had the same summary: "[Client #6] ran away from group home on 7-13th-2023...he was missing for over 10 hours or more and was taking to the Hospital on that day for PTSD and Suicide and Anxiety feelings to [Local hospital] for 7 days."
- September - December 2023 progress notes all had the same summary: "[Client #6]...went to the Hospital on SEPTEMBER 28th 2023 for Suicide Attempt..."
- None of the progress notes provided information on whether or not client #6 verbalized threats of suicide or thoughts of suicidal ideation

Review on 1/24/24 of the facility's records revealed:
- Client #6's after visit hospital summary dated 7/20/23: "You (client #6) were admitted to [Local Hospital Behavioral Health] for symptoms of suicidal thoughts..."

Interview on 1/24/24 client #6 reported:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 113	Continued From page 16 - Was "depressed" and "not wanting to be alive anymore" - "Tried to commit suicide" - "Been thinking about it (suicide) all my life" - Cut his arm with broken glass and eloped on 7/13/23 - "Went to the hospital because I had thoughts to kill myself" on 7/13/23 - Attempted suicide 9/27/23 Interviews on 1/25/24 and 1/31/24 the Residential Manager reported: - Client #6 expressed thoughts of suicidal ideation, but "not often" - Client #6 would say "I feel like I want to kill myself" - Staff didn't document when client #6 expressed thoughts of suicidal ideation or made threats of suicide because client #6 didn't do it "often" - She was responsible for writing the clients' progress notes - She didn't include how often client #6 verbalized thoughts of suicidal ideation because "he didn't say it at the group home often" - Client #6 did have a ABC (antecedent, behavior, and consequence) data sheet, but staff didn't document when he verbalized thoughts of suicidal ideation or threats of suicide Interview on 1/30/24 the Qualified Professional (QP) reported: - The Residential Manager was responsible for writing the clients' progress notes - Client #6's thoughts of suicidal ideation and threats of suicide were documented on his ABC data sheet, but he needed to check with the Residential Manager because "He (client #6) may not have a ABC data sheet" - Planned to develop a ABC data sheet for	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 113	Continued From page 17 client #6 if he didn't already have one - He reviewed and signed off on the clients' progress notes, but he hadn't realized the Residential Manager hadn't documented client #6's thoughts of suicidal ideation in the progress notes Interview on 1/31/24 the Executive Director reported: - The Residential Manager was responsible for writing the clients' progress notes - The QP was responsible for overseeing the clients' progress notes - Client #6's thoughts of suicidal ideation and threats of suicide were supposed to be documented on a ABC data sheet - Was unaware that client #6's thoughts of suicidal ideation and threats of suicide were not documented on client #6's ABC data sheet or progress notes	V 113		
V 119	27G .0209 (D) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (d) Medication disposal: (1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion. (2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction.	V 119		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 119	Continued From page 18 (3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. (4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to dispose of medication affecting 1 of 3 audited clients (#6). The findings are: Review on 1/23/24 of client #6's record revealed: - Admitted 1/24/2020 - Diagnoses of Mild Intellectual Developmental Disorder, Autism Spectrum Disorder (Asperger's), Persistent Depressive Disorder, Posttraumatic Stress Disorder, and Gender Dysphoria - Physician's order dated 11/30/23 for Proair Inhale two puffs by mouth every 4 hours PRN (as needed) (Asthma/Wheezing) Observation 1/23/24 of client #6's medication bin revealed: - Proair Inhaler with an expiration date of 8/30/23 Interview on 1/24/24 client #6 reported: - Had an inhaler for "wheezing" due to a	V 119		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 119	Continued From page 19 previous cold - Didn't use the inhaler - Last used the inhaler "about a year ago" Interview on 1/24/24 staff #1 reported: - Client #6 hadn't used his inhaler - Didn't know the inhaler was expired - The Registered Nurse (RN) was responsible for disposing of medications Interview on 1/24/24 staff #2 reported: - Saw client #6's inhaler was expired, but she "can't remove (dispose) medications" - The RN was responsible for disposing the clients' medications - She "forgot to tell [RN] it (client #6's inhaler) was expired" Interview on 1/29/24 the RN reported: - Came to the facility and checked medications every three months - Checked for expired medications - Responsible for ensuring medications were discarded - Staff can dispose of medications "if they felt comfortable" - Some staff would "take care of it (medication), some will put it back until I come" - Two staff could dispose of the medication by taking the medications to the sheriff's office and discarding the medication in a secure medication box known as the "drug buster" - Was unaware client #6's inhaler had expired and was not disposed of - Staff could have disposed of the inhaler by "putting it in the trash" Interview on 1/24/24 the Residential Manager reported: - Was unaware client #6's inhaler had expired	V 119		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 119	Continued From page 20 - The RN was responsible for "overseeing" disposals - The RN came to facility every three months - Two staff could dispose of medications in a "thermal cup" or "flush" it down a commode Interview on 1/30/24 the Qualified Professional reported: - The RN was responsible for overseeing the medications in the facility Interview on 1/31/24 the Executive Director reported: - The RN and staff were responsible for discarding medications - Was unaware client #6's inhaler had expired and hadn't been discarded - Staff or the RN disposed of medications by returning it to the pharmacy or dissolving the medicine	V 119		
V 364	G.S. 122C- 62 Additional Rights in 24 Hour Facilities § 122C-62. Additional Rights in 24-Hour Facilities. (a) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-61, each adult client who is receiving treatment or habilitation in a 24-hour facility keeps the right to: (1) Send and receive sealed mail and have access to writing material, postage, and staff assistance when necessary; (2) Contact and consult with, at his own expense and at no cost to the facility, legal counsel, private physicians, and private mental health, developmental disabilities, or substance abuse professionals of his choice; and (3) Contact and consult with a client advocate if	V 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 119	Continued From page 20 - The RN was responsible for "overseeing" disposals - The RN came to facility every three months - Two staff could dispose of medications in a "thermal cup" or "flush" it down a commode Interview on 1/30/24 the Qualified Professional reported: - The RN was responsible for overseeing the medications in the facility Interview on 1/31/24 the Executive Director reported: - The RN and staff were responsible for discarding medications - Was unaware client #6's inhaler had expired and hadn't been discarded - Staff or the RN disposed of medications by returning it to the pharmacy or dissolving the medicine	V 119		
V 364	G.S. 122C- 62 Additional Rights in 24 Hour Facilities § 122C-62. Additional Rights in 24-Hour Facilities. (a) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-61, each adult client who is receiving treatment or habilitation in a 24-hour facility keeps the right to: (1) Send and receive sealed mail and have access to writing material, postage, and staff assistance when necessary; (2) Contact and consult with, at his own expense and at no cost to the facility, legal counsel, private physicians, and private mental health, developmental disabilities, or substance abuse professionals of his choice; and (3) Contact and consult with a client advocate if	V 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 364	Continued From page 21 there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each adult client may exercise these rights at all reasonable times. (b) Except as provided in subsections (e) and (h) of this section, each adult client who is receiving treatment or habilitation in a 24-hour facility at all times keeps the right to: (1) Make and receive confidential telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over therapies; (3) Communicate and meet under appropriate supervision with individuals of his own choice upon the consent of the individuals; (4) Make visits outside the custody of the facility unless: a. Commitment proceedings were initiated as the result of the client's being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the respondent was found not guilty by reason of insanity or incapable of proceeding; b. The client was voluntarily admitted or committed to the facility while under order of commitment to a correctional facility of the Division of Adult Correction of the Department of Public Safety; or c. The client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; A court order may expressly authorize visits otherwise prohibited by the existence of the conditions prescribed by this subdivision; (5) Be out of doors daily and have access to	V 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 364	Continued From page 21 there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each adult client may exercise these rights at all reasonable times. (b) Except as provided in subsections (e) and (h) of this section, each adult client who is receiving treatment or habilitation in a 24-hour facility at all times keeps the right to: (1) Make and receive confidential telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over therapies; (3) Communicate and meet under appropriate supervision with individuals of his own choice upon the consent of the individuals; (4) Make visits outside the custody of the facility unless: a. Commitment proceedings were initiated as the result of the client's being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the respondent was found not guilty by reason of insanity or incapable of proceeding; b. The client was voluntarily admitted or committed to the facility while under order of commitment to a correctional facility of the Division of Adult Correction of the Department of Public Safety; or c. The client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; A court order may expressly authorize visits otherwise prohibited by the existence of the conditions prescribed by this subdivision; (5) Be out of doors daily and have access to	V 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 364	Continued From page 22 facilities and equipment for physical exercise several times a week; (6) Except as prohibited by law, keep and use personal clothing and possessions, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; (7) Participate in religious worship; (8) Keep and spend a reasonable sum of his own money; (9) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes; and (10)Have access to individual storage space for his private use. (c) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-57 and G.S. 122C-59 through G.S. 122C-61, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to have access to proper adult supervision and guidance. In recognition of the minor's status as a developing individual, the minor shall be provided opportunities to enable him to mature physically, emotionally, intellectually, socially, and vocationally. In view of the physical, emotional, and intellectual immaturity of the minor, the 24-hour facility shall provide appropriate structure, supervision and control consistent with the rights given to the minor pursuant to this Part. The facility shall also, where practical, make reasonable efforts to ensure that each minor client receives treatment apart and separate from adult clients unless the treatment needs of the minor client dictate otherwise. Each minor client who is receiving treatment or habilitation from a 24-hour facility has the right to: (1) Communicate and consult with his parents or guardian or the agency or individual having legal custody of him;	V 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 364	Continued From page 23 (2) Contact and consult with, at his own expense or that of his legally responsible person and at no cost to the facility, legal counsel, private physicians, private mental health, developmental disabilities, or substance abuse professionals, of his or his legally responsible person's choice; and (3) Contact and consult with a client advocate, if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each minor client may exercise these rights at all reasonable times. (d) Except as provided in subsections (e) and (h) of this section, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to: (1) Make and receive telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Send and receive mail and have access to writing materials, postage, and staff assistance when necessary; (3) Under appropriate supervision, receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over school or therapies; (4) Receive special education and vocational training in accordance with federal and State law; (5) Be out of doors daily and participate in play, recreation, and physical exercise on a regular basis in accordance with his needs; (6) Except as prohibited by law, keep and use personal clothing and possessions under appropriate supervision, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; (7) Participate in religious worship;	V 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 364	Continued From page 24 (8) Have access to individual storage space for the safekeeping of personal belongings; (9) Have access to and spend a reasonable sum of his own money; and (10)Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes. (e) No right enumerated in subsections (b) or (d) of this section may be limited or restricted except by the qualified professional responsible for the formulation of the client's treatment or habilitation plan. A written statement shall be placed in the client's record that indicates the detailed reason for the restriction. The restriction shall be reasonable and related to the client's treatment or habilitation needs. A restriction is effective for a period not to exceed 30 days. An evaluation of each restriction shall be conducted by the qualified professional at least every seven days, at which time the restriction may be removed. Each evaluation of a restriction shall be documented in the client's record. Restrictions on rights may be renewed only by a written statement entered by the qualified professional in the client's record that states the reason for the renewal of the restriction. In the case of an adult client who has not been adjudicated incompetent, in each instance of an initial restriction or renewal of a restriction of rights, an individual designated by the client shall, upon the consent of the client, be notified of the restriction and of the reason for it. In the case of a minor client or an incompetent adult client, the legally responsible person shall be notified of each instance of an initial restriction or renewal of a restriction of rights and of the reason for it. Notification of the designated individual or legally responsible person shall be documented in writing in the client's record.	V 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 364	Continued From page 25	V 364		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure the restriction of 1 of 3 client's (#6) access to personal property had a written statement detailing the reason for the restriction and failed to review the restriction as required. The findings are:

Review on 1/24/24 of the facility's records revealed:
- A meeting summary dated 10/20/23: "[Client #6] will turn off all electronics devices (hand held game system and IPad) nightly at 9:00pm"
- An electronic plan data sheet for client #6 that was implemented on 7/21/23 for the use of daily documentation of "Structure use of Electronics" and provided the following instructions: "[Client #6] is very attached to his electronic games, and his IPad...At 9pm staff will prompt [client #6] to turn in his electronics to the office."
- No documentation from client #6's guardian regarding turning in his electronics at night

Interview on 1/24/24 client #6 reported:
- Had to give staff his electronics every night "so I won't stay up late"
- "Don't mind" turning his electronics in at night

Interviews on 1/30/24 and 1/31/24 the Qualified Professional (QP) reported:
- The treatment team agreed to limit client #6's use of his electronics at night after he was involuntarily committed on 7/13/23
- Client #6 turned in his electronics to staff every night
- Didn't know he had to write a written

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 364	Continued From page 26 statement detailing the reason for the restriction or review the restriction every 7 days - Thought the letter from client #6's guardian could be used as the written statement detailing the reason for the restriction Interview on 1/31/24 the Executive Director reported: - The treatment team agreed to limit client #6's use of his electronics at night - Client #6 gave staff his electronics every night - Client #6's guardian requested for client #6 to turn in his electronics every night - Didn't "think" client #6 turning in his electronics was a rights restriction since the guardian requested it - Wasn't aware the facility was restricting client #6's rights because the facility was "honoring the guardian's request" to limit client #6's use of his electronics - Considered the letter provided by client #6's guardian representative as the written statement for detailing the reason for the rights restriction - Didn't think the rights restriction needed to be reviewed every 7 days because the "we're (Legacy Human Service, LLC) not restricting client #6's rights, his guardian is" This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 violation and must be corrected within 23 days.	V 364		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 512	Continued From page 27 (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by: Based on record review and interview, 1 of 3 audited paraprofessionals (#2) neglected 1 of 3 audited clients (#6). The findings are: Review on 1/23/24 of client #6's record revealed: - Admitted 1/24/20 - Diagnoses of Mild Intellectual Developmental Disorder, Autism Spectrum Disorder (Asperger's), Persistent Depressive Disorder, Posttraumatic Stress Disorder, History of self harm and suicidal ideation, and Gender Dysphoria - A Psychological Evaluation with the latest date of evaluation listed as 2/13/18: "Suicide	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 512	Continued From page 28 threats and behaviors occur after he (client #6) gets upset when he does not get his way...His biological mother...reportedly blamed him for things...He stills idealizes her and seems to follow suit in self-blame when he is upset, which then results in self-harm and/or suicidal ideations." Review on 1/24/24 of staff #2's personnel record revealed - Hired 9/16/20 - Medication Administration training certificate dated 9/12/23 - Cardiopulmonary Resuscitation (CPR) and first aid certificate dated 9/16/22 Review on 1/29/24 of the facility's Medication Administration PowerPoint presentation training (no date) revealed the following topics: - Signs and symptoms of illnesses - Signs and symptoms of lithium toxicity Review of 1/24/24 of the facility's Emergency Preparedness Plan for Medical Emergencies/Serious Illness or Injury revealed: - "In the event of a serious injury or illness to any individual of the group home, the immediate concern is to assist the injured or sick person in obtaining treatment...If the need is critical, the group home manager or designee will immediately have someone call 911 while he or she stays with the individual..." Review on 1/25/24 of a level II incident report written by staff #2 and dated 9/27/23 revealed: - "I called [client #6] 2 times for Dinner he didn't come so I went to his room and he was looking like he could barely keep his eyes open. I called [Residential Manager] to ask her can she come to the group home. I gave him his PRN (as needed) (Hydroxyzine 25 milligrams (mg)) and she told me	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 512	Continued From page 29 if I need her to call her and I immediately call back in 5 mins (minutes) and she said I am on my way. When she arrived we both went in his room we was told by the 911 lady to hold his head back then put him in the floor to begin CPR until the emergency squad arrived then they took over..." Review on 1/25/24 of client #6's Emergency Medical Service (EMS) run sheet dated 9/27/23 revealed: - "Pt (patient) is found on floor of bedroom with staff performing CPR. Pt has white powdery substance in his mouth, staff advised they had given him medication just prior to him becoming unresponsive." - "Dispatched by 911 ref (reference) unresponsive. When enroute central advised pt has possibly in cardiac arrest. On arrival CPR was in progress by staff....Staff advised that pt was starting to 'act up' so they administered his PRN medication (Hydroxyzine 25 milligram (mg)) for agitation, and he became unresponsive shortly after. Staff state that pt is known to try self-harm and may have taken additional medication that may not be his..." Review on 1/25/24 of an investigation conducted by the Executive Director dated 9/29/23 revealed: - "Staff (staff #2) reported to [Residential Manager] that she administered [client #6]'s 25mg of Hydrazine PRN and after calling him for dinner twice, went to check on him, and found him a little responsive on his bed...[Residential Manager] stated she was at the house within 12 minutes...the doctor from [local hospital] called... [client #6] tox (toxicology) screening came back and he had Lithium Toxicity" Interview on 1/24/24 client #6 reported: - Was "depressed" and "not wanting to be alive	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 512	Continued From page 30 anymore" - "Tried to commit suicide" - "Tried all my life" - "OD'd (overdosed) off Lithium" - "Snuck" his Lithium in his room by holding it in his mouth after receiving his medications in the facility - Took the Lithium pills around 4pm - Didn't recall staff #2 coming in his room to get him for dinner Interview on 1/25/24 staff #2 reported: - Was trained in CPR, first aid and medication administration - Knew that "you can tell by looking at a person" if they were acting outside of their normal behavior and knew to "call 911" in emergencies - On 9/27/23, client #6 got an "attitude" he didn't have access to client #1's WiFi - Around 6:30pm, she called client #6 twice to eat dinner and he didn't come She went to his room and asked client #6 what was wrong and he said "nothing" - Gave him his PRN medication (Hydroxyzine 25mg) - Client #6 "didn't look right...just staring (at her) and mumbling...he never got up (out of bed)" - Client #6 "talked awhile (mumbling) and stopped...just staring" - "It (client #6 behavior) was different from his norm (normal behavior) because he's happy and talkative" - Called the Residential Manager because she thought client #6 was "acting out (behavior)" - Called the Residential Manager back when she saw client #6's "eyes roll back in his head," he was "making a grunting noise" and was no longer "speaking" - Knew client #6's "eyes rolling back" and "grunting noises" wasn't "normal"	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 512	Continued From page 31 - The Residential Manager "got here (the facility) in five minutes" after the second phone call - Client #6 was unresponsive when she and the Residential Manager went into his room - Stayed in the room with client #6, but she could not recall when client #6 went unconscious - The Residential Manager called 911 when client #6's arm "flopped" down off the bed after she touched him - Knew to call 911, but the Residential Manager was "on the way" and "I knew she (Residential Manager) would call (911)" - She had started performing CPR compressions before the Residential Manager called 911 - Client #6 had a pulse but was "gasping" for breath Interview on 1/29/24 the CPR Instructor reported: - Was a CPR and first aid instructor for "30 plus years" - Taught CPR and first aid for Legacy Human Services, LLC (Licensee) - Staff #2 completed his CPR and first aid class 9/16/22 - "I teach staff to recognize a crisis and get help (call 911) as soon as possible," and "follow their policy and procedure for emergency response" - Staff should "make a patient assessment and if there is no protocol, call 911" - "Anytime they (clients) are not responding, call 911" Interview on 1/29/24 the Registered Nurse reported: - Was a nurse consultant for Legacy Human Services, LLC (Licensee) - Trained staff #2 on medication administration	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 512	Continued From page 32 and signs and symptoms of illnesses - She trained staff #2 on identifying signs and symptoms of lithium toxicity - "Staff knows the residents better than anyone. If there is something different with a client, pay attention, document, and if you don't think you can handle the situation then call 911 and have them come and assess" the clients Interviews on 1/23/24 and 1/25/24 the Residential Manager reported: - On 9/27/23, staff #2 called her and said client #6 was "crying" and saying "he (client #6) didn't feel right" - Spoke with client #6 on the phone and he was upset but she "couldn't understand him" - Staff #2 told her that client #6 asked for his PRN medication and asked "when [client #1] was coming back" - Staff #2 said she thought client #6 was "acting out" because he wanted to use client #1's WiFi - Staff #2 told her that client #6 returned to his bedroom - Staff #2 said she "called him (client #6) for dinner and he didn't respond" - Staff #2 said she "called him again and he (client #6) didn't respond so she (staff #2) went to the room and said he was 'looking out of it'" - Staff #2 "called me back and said 'something is wrong with [client #6]" - Staff #2 "came back to the staff office and she (staff #2) was giving out clients' meds (medications), and by that time I had arrived" to the facility - She went into client #6's room and he was "slumped over" - "[Client #6] wasn't responding...had foam coming out of his mouth and his eyes won't looking right"	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 512	Continued From page 33 - She called 911 and dispatch instructed her to lay client #6 flat on the floor and there was "no movement" from client #6 - Staff #2 began CPR - When she relieved staff #2 from performing CPR and while she was doing chest compressions client #6 "took a breath" - Lived "about 9 to 10 minutes" away from the facility in a neighboring city - Could not recall how much time had passed from when she received the second call from staff #2 to when she arrived at the facility - "Don't know why [staff #2] didn't call 911" - "She (staff #2) thought he (client #6) was just laying down and he was sleep" - "Don't know why she (staff #2) didn't call 911 after she said client #6 'looked out of it'" - She "spoke with her (staff #2) afterwards and told her "that she needed to call 911 first when clients weren't acting right" Interviews on 1/25/24 and 1/31/24 the Executive Director reported: - Client #6 ingested his Lithium pills on 9/27/23 - Staff #2 called both 911 and the Residential Manager - Was unaware the Residential Manager called 911 on 9/27/23 - Staff #2 "didn't know what was wrong with him (client #6)" and she "called [Residential Manager] to assess the situation and determine if 911 was needed" - "[Staff #2] stayed with [client #6] the whole time" - Didn't know why staff #2 didn't call 911 "you're going to have to ask her" - Investigated client #6's suicide attempt on 9/27/23 and "I did not find it as neglect" - "No one knew that he (client #6) had overdosed until months later"	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 512	Continued From page 34 - "Don't agree that [staff #2] neglected [client #6]" - "We (Legacy Human Services, LLC) saved his (client #6's) life" - "Usually when there's a positive outcome it doesn't matter" who called 911 Review on 1/25/24 of a Plan of Protection dated 1/25/24 and written by the Executive Director revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? -Today, 1/25/24, all staff at the Oxford Group Home will receive inservice training on the medical emergency policy for calling 911. -Within 2 weeks, [staff #2] will receive CPR/First Aid by 2/8/2024. Describe your plans to make sure the above happens. Executive Director will give a directive to the Residential Manager to complete the inservice today. The Executive Director will schedule a CPR/First Aid Class prior to 2/8/24 for [staff #2]." Client #6 had a diagnoses of Mild Intellectual Developmental Disorder, Autism Spectrum Disorder Asperger's, Persistent Depressive Disorder, Posttraumatic Stress Disorder and history of self harm and suicidal thoughts. Staff #2 did not call 911 when she observed client #6's in his bedroom with his eyes rolling back in his head, making grunting noises, and was no longer speaking. Staff #2 called the Residential Manager to the facility, but did not immediately seek assistance from EMS as trained. Staff #2 waited for the Residential Manager to arrive at the facility to call 911, which resulted in a 12 minute delay. Upon her arrival, the Residential Manager found client #6 unresponsive, called 911, and was directed by 911 to perform CPR. This deficiency constitutes a Type A1 rule violation for serious	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 512	Continued From page 35 neglect and must be corrected within 23 days.	V 512		

Legacy Human Services, Inc.

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

February 20, 2024

Mental Health Licensure and Certification Section

NC Department of Health and Human Services

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 Type A1 Administrative Penalty and the standard level deficiencies cited at the Oxford Group Home, Located at 605 N. Country Club Drive, Oxford, NC 27565. This is in conjunction with MHL #: 039-062.

You shall find upon return that all deficiencies cited have been addressed globally and the correction has been made prior to the correction date of February 23, 2024. 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,

Jacinta Johnson

Executive Director

ASPIRE to Excellence® carf ACCREDITED

Plan of Correction – Oxford

Date of Correction: February 23, 2024

Deficiency Cited: V108: 27G.0202 Personnel Requirements. Based on record reviews and interviews, the facility failed to ensure that staff had training to meet MH/DD/SA needs of the client.

Provider's Plan of Correction: Legacy Human Services, Inc. will ensure that each staff member is trained in client specific needs including Mental Health Signs and Symptoms. The Executive Director has reached out on 2/9/2024 to VAYA Health and scheduled "Question, Persuade, Refer (QPR) Suicide Prevention Training" for the earliest time available, which is 2/26/2024 from 1pm – 3pm. This training is mandatory for all Direct Support Professionals, Residential Manager, and QP of the Oxford Group Home.

Responsible Parties: Direct Support Professionals, Residential Manager, QP, and Executive Director

Correction Date: 2/23/2024

Deficiency Cited: V109: 27G. 0203 Privileging / Training Professionals. The facility failed to ensure the QP demonstrated the knowledge, skills and abilities required by the population served and educated staff on the enforcement of individuals' rights.

Provider's Plan of Correction: Legacy Human Services, Inc. will ensure that the QP meets his job description to "assess training needs, coordinate the orientation training and on-going and in-service training for direct care staff". Effective 1/31/2024, all guardian requested structured plans will no longer be honored. Restrictions of rights, even those imposed by guardians, will be reviewed at a PCP meeting and evaluated for necessity. The QP will participate in ongoing clinical training to address gaps in skillset including Mental Health issues which are documented. The Executive Director will complete a QP Core Competency Checklist with the QP to determine strengths and weaknesses, and seek support from MCOs, NC Medicaid, and NC DHHS resources to align training to bridge those gaps.

Responsible Parties: QP and Executive Director.

Correction Date: 2/23/2024 and ongoing

Deficiency Cited: V112: 10A NCAC 27G.0205. Assessment and Treatment / Habilitation or Service Plan. The facility failed to develop and implement goals and strategies to address client's needs.

Provider's Plan of Correction: Legacy Human Services, Inc. will ensure that each client receives a current and relevant Person-Centered Plan inclusive of revisions stemming from hospitalizations and changes in diagnosis and needs. Upon discharge from a psychiatric hospitalization, the team will meet to update the PCP plan to implement the diagnosis, signs and symptoms, updates to crisis plan, new services such as CST, new goals and identifying needs for which services may not be available, such as Behavior Support Plan, and how these changes will be addressed. For client [redacted] the PCP was updated on 2/5/2024.

Responsible Parties: Residential Manager, QP, Treatment Team, and Executive Director

Correction Date: 2/23/2024

Deficiency Cited: V113: 10A NCAC 27G. 0206. Client Records. The facility failed to ensure that the client record contained full documentation of services provided and progress towards the outcomes.

Provider's Plan of Correction: Legacy Human Services, Inc. will assure that ABC data for targeted behavioral data collection will be documented in the progress note. The Residential Manager and the QP will work together to make sure that the notes reflect all data available.

Responsible Parties: Residential Manager and QP

Correction Date: 2/23/2024

Deficiency Cited: V119: 27G.0209. Medication Requirements. The facility failed to assure that all medications are disposed of in a manner that guards against diversion or accidental ingestion.

Provider's Plan of Correction: Legacy Human Services, Inc. will ensure that all outdated medications or discarded medications are disposed of based on the agency's approved disposal policy. Staff will receive an additional In-Service to alert them of the disposal requirements.

Responsible Parties: Residential Manager, QP, RN, and Executive Director

Correction Date: 2/23/2024

Deficiency Cited: V364: 122C – 62. Additional Rights in 24-Hour Facilities. The facility failed to ensure that the restriction of client's individual property had a written statement detailing the reason for the restriction and failed to review the restriction as required.

Provider's Plan of Correction: Effective 1/31/2024, the agency will no longer honor guardian's requests for restrictions without a PCP meeting to discuss the reasoning, the time limitations,

and documenting every 7 days the necessity for the restriction. For client [redacted] those restrictions were lifted immediately on 1/31/2024 and discussed at PCP revision meeting on 2/5/2024.

Responsible Parties: Residential Manager, QP, and Executive Director

Correction Date: 1/31/2024

Deficiency Cited: V512: 10A NCAC 27D .0304. Protection from Harm, Abuse, Neglect or Exploitation. The agency staff failed to recognize and assess the crisis on 9/27/2023 and failed to call 911 before calling the supervisor for assistance in assessing the situation.

Provider's Plan of Correction: The agency staff will accurately recognize and assess a crisis, and "when in doubt call 911". The Plan of Protection will be implemented completely including immediate In-Service Training for all staff regarding calling 911. The staff involved in the crisis will receive CPR/FA class again on 2/2/2024. All staff of the home, including management and QP will attend a Suicide Prevention and Awareness Class sponsored by VAYA at the earliest scheduled date that is available which is 2/26/2024.

Responsible Parties: Direct Support Staff, Residential Manager, QP, and Executive Director

Correction Date: 2/23/2024

Provider Signature: _____ EXECUTIVE DIRECTOR

2/20/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 follow up survey was completed on January 31, 2024. 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 6 and currently has a census of 6. The survey sample consisted of audits of 3 current clients.	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 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.	V 108	RECEIVED FEB 26 2024 DHSR-MH Licensure Sect	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 364	Continued From page 23 (2) Contact and consult with, at his own expense or that of his legally responsible person and at no cost to the facility, legal counsel, private physicians, private mental health, developmental disabilities, or substance abuse professionals, of his or his legally responsible person's choice; and (3) Contact and consult with a client advocate, if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each minor client may exercise these rights at all reasonable times. (d) Except as provided in subsections (e) and (h) of this section, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to: (1) Make and receive telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Send and receive mail and have access to writing materials, postage, and staff assistance when necessary; (3) Under appropriate supervision, receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over school or therapies; (4) Receive special education and vocational training in accordance with federal and State law; (5) Be out of doors daily and participate in play, recreation, and physical exercise on a regular basis in accordance with his needs; (6) Except as prohibited by law, keep and use personal clothing and possessions under appropriate supervision, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; (7) Participate in religious worship;	V 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 108	Continued From page 1 (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 3 of 3 audited paraprofessional staff (#1, #2 & Residential Manager) and 1 of 1 Qualified Professional (QP) had training to meet mh/dd/sa needs of the client. The findings are: Review on 1/24/24 of staff #1's personnel record revealed: - Hired 6/8/23 - No documentation for suicide awareness and prevention training Review on 1/24/24 of staff #2's personnel record revealed: - Hired 9/16/20 - No documentation for suicide awareness and prevention training Review on 1/24/24 of the Residential Manager's personnel record revealed: - Hired 1/1/21 - No documentation for suicide awareness and prevention training Review on 1/25/24 of the QP's personnel record revealed: - Hired 3/10/14 - No documentation for suicide awareness and	V 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 108	Continued From page 2 prevention training Interview on 1/24/24 staff #1 reported: - Was "pretty sure" she had training in suicide awareness and prevention - Client #6 was "very depressed" and attempted suicide on 9/27/23 - Knew to report "anything other than his (client #6) normal self" to the Residential Manager Interview on 1/24/24 staff #2 reported: - Client #6 attempted suicide on 9/27/23 - Hadn't had training in suicide awareness and prevention - Knew that "you can tell by looking at a person" if they were acting outside of their normal behavior Interview on 1/29/24 the Cardiopulmonary Resuscitation (CPR) Instructor reported: - Suicide awareness and prevention was not covered in the CPR and first aid curriculum Interview on 1/29/24 the Registered Nurse (RN) reported: - Was a nurse consultant for the facility - Was responsible for conducting medication administration training in the facility - She spoke with the Executive Director and provided the facility a suicide awareness and prevention training guide last week - She planned to train staff on suicide awareness and prevention "soon" Interview on 1/24/24 the Residential Manager reported: - Client #6 eloped on 7/13/23 and was involuntarily committed at a local hospital for thoughts of suicidal ideation - Client #6 attempted suicide on 9/27/23	V 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 108	Continued From page 3 - "Never" received training on suicide awareness and prevention - "Will probably have to get the nurse (RN) to do a training" Interview on 1/30/24 the QP reported: - Responsible for "trainings that will help improve staff and clients knowledge" in the facility - Hadn't received training in suicide awareness and prevention - "Suicide training is outside of my scope" - A therapist was responsible for training staff in suicide awareness and prevention, but "I don't know, I could be wrong" - Didn't contact a therapist to coordinate suicide awareness and prevention training because "It (client #6's suicide attempt) was a one time thing" Interviews on 1/24/24 and 1/31/24 the Executive Director reported: - Client #6 was Legacy Human Service LLC's (Licensee) first client to attempt suicide - Didn't have a training for suicide awareness and prevention - Suicide awareness and prevention was covered in CPR and First Aid - The agency didn't have anyone to conduct a training on suicide awareness and prevention - Planned to try to locate someone to conduct the suicide awareness and prevention training This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 violation and must be corrected within 23 days.	V 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 109	Continued From page 4	V 109		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter.	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 109	Continued From page 5	V 109		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure 1 of 1 Qualified Professional (QP) demonstrated the knowledge, skills and abilities required by the population served. The findings are:

A. Cross reference: 10A NCAC 27G .0202 Personnel Requirements (V108). Based on record review and interview, the facility failed to ensure 3 of 3 audited paraprofessional staff (#1, #2 & Residential Manager) and 1 of 1 Qualified Professional (QP) had training to meet mh/dd/sa needs of the client.

B. Cross reference: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112). Based on record review and interview, the facility failed to develop and implement strategies to address 1 of 3 audited client's needs (#6).

C. Cross reference: GS 122C-62. Additional Rights in 24-Hour Facilities (V364). Based on record review and interview, the facility failed to ensure the restriction of 1 of 3 client's (#6) access to person property had a written statement detailing the reason for the restriction and failed to review the restriction as required.

Review on 1/25/24 of the QP's personnel record revealed:
- A signed job description dated 4/6/21:
- "Assess training needs, coordinate the orientation training and on-going and in-going service training for direct care staff"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 109	Continued From page 6 - "Ensure that all services, programming, treatment plans and required documentation are developed and implemented accurately and on a timely basis." - "Educate staff and enforce the individuals' rights and services." Review on 1/31/24 of a Plan of Protection dated 1/31/24 and written by the Executive Director/QP revealed: "1) As of today, within 23 days, the team of Legacy Human Services (Licensee) will schedule a meeting with the guardian to discuss, plan, and determine a plan of action for their requested restrictions of [client #6's initials]'s electronics. 2) As of today, within 23 days, the team will search for a credable clinician to provide suicide awareness and prevention training for staff. 3) As of today, the PCP (Person Centered Plan) will be updated within 23 days to reflect the changes and new steps to address [client #6's initials]'s needs. #4) As of today, within the next 23 days, the Executive Director will seek and provide additional training to the Q.P. regarding clinical competencies. Describe your plans to make sure the above happens. -The Executive Director/QP will schedule the team meeting to discuss #1. -The Executive Director/QP will seek a credible clinician to teach suicide awareness and prevention. -The Executive Director/QP will facilitate a revised PCP for [client #6's initials]. -The E.D. (Executive Director)/QP will facilitate additional QP training." Client #6 had diagnoses of Mild Intellectual Developmental Disorder, Autism Spectrum Disorder Asperger's, Persistent Depressive Disorder, and Posttraumatic Stress Disorder. Client #6 had history of thoughts of suicidal ideation and threats of suicide. Client #6 was	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 109	Continued From page 7 involuntary committed on 7/13/23 for thoughts of suicidal ideation. Client #6 attempted suicide on 9/27/23. The QP did not train staff nor coordinate with a qualified instructor to train staff on suicide awareness and prevention. The QP was responsible for developing and updating client #6's treatment plan. There were no goals and strategies to address client #6's verbal threats of suicide or attempted suicide. Client #6's treatment plan did not include strategies to decrease thoughts of suicidal ideation and threats of suicide, or structure the use of client #6's electronics. Also, client #6's treatment plan was not updated to include strategies to prevent cheeking medications. Client #6 was required to turn in his game system and IPad to staff at 9pm every night. This restriction on his rights did not have a written statement detailing the reason nor was it reviewed every 7 days. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 109		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible;	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 112	Continued From page 8 (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop and implement goals and strategies to address 1 of 3 audited client's needs (#6). The findings are: Review on 1/23/24 of client #6's record revealed: - Admitted 1/24/20 - Diagnoses of Mild Intellectual Developmental Disorder, Autism Spectrum Disorder (Asperger's), Persistent Depressive Disorder, Posttraumatic Stress Disorder (PTSD), and Gender Dysphoria - A Psychological Evaluation with the latest date of evaluation listed as 2/13/18: "Suicide threats and behaviors occur after he (client #6) gets upset when he does not get his way...His biological mother...reportedly blamed him for things...He stills idealizes her and seems to follow suit in self-blame when he is upset, which then results in self-harm and/or suicidal ideations." - A progress note dated 1/3/24: "[Client #6] ran	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 112	Continued From page 9 away from the group home on 7-13th-2023...was taking to the Hospital on that day for PTSD and Suicide and Anxiety feelings to [Local Hospital] for 7 days...he (client #6) went to the Hospital on September 28th 2023 for Suicide Attempt..." - A treatment plan dated 9/19/23: "In the past he tried to harm himself close monitoring is required." - The treatment plan didn't contain goals or strategies for: - Thoughts of suicidal ideation and threats of suicide - Structured use of electronics - No updated treatment plan to address his suicide attempt on 9/27/23 Review on 1/24/24 of the facility's records revealed: - Client #6's After Visit Hospital Summary dated 7/20/23: "You (client #6) were admitted to [Local Hospital Behavioral Health] for symptoms of suicidal thoughts..." Interview on 1/24/24 client #6 reported: - Had goals to clean the house and exercise - Had more goals but could not recall them - Was "depressed" and "not wanting to be alive anymore" - "Been thinking about it (suicide) all my life" - Cut his arm with broken glass and eloped on 7/13/23 - "Went to the hospital because I had thoughts to kill myself" on 7/13/23 - Attempted suicide 9/27/23 - Overdosed on his Lithium pills - "Held it (Lithium pills) in my mouth between my teeth" after receiving his medications - Been "cheeking" his Lithium pills for "months" - After 9/27/23, staff monitored him for "cheeking" medication by checking his "whole	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 112	Continued From page 10 mouth" including "under my tongue" and he "drinks extra water" after his medications were administered to him - Staff searched his bedroom "once a week" - Had to give staff his electronics (game system and IPad) at 9pm every night "so I won't stay up late" Interview on 1/24/24 staff #1 reported: - Received "basic training of everyone's (clients') behavior and changes and more specific training with [client #6]" - Knew client #6 was "very depressed" - Close monitoring in client #6's treatment plan meant client #6 "can't be alone" - Didn't know how often she needed to check on client #6, but she "checked on them (clients) every 15 minutes anyway" Interview on 1/24/24 staff #2 reported: - Close monitoring in client #6's treatment plan meant to check on client #6 "every two hours" to "see he's doing good" - Knew client #6 had thoughts of suicidal ideation and made threats of suicide - Client #6 would say "I want to kill myself when he's upset" - Knew to give client #6 his PRN (as needed) medication of Hydroxyzine 25 milligrams (mg) when he became upset Interview on 1/30/24 client #6's Psychiatrist reported: - First visit with client #6 was 10/7/19 - Client #6 had a "long term history" of self-harm, thoughts of suicidal ideation, and threats of suicide - Client #6 made comments such as "I don't feel right...I don't feel good..or I think about killing myself" when he became "upset about	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 112	Continued From page 11 something" - Client #6 was involuntarily committed into hospitals several times due to thoughts of suicidal ideation and threats of suicide - Client #6 "would have thoughts on it but hadn't ever acted" until 9/27/23 Attempted interviews on 1/31/24 with client #6's therapist were unsuccessful because she had retired and had not returned the phone calls prior to exit of the survey. Interviews on 1/23/24 and 1/24/24 the Residential Manager reported: - Client #6 would express thoughts of suicidal ideation, but "not often" - Client #6 would say "I feel like I want to kill myself" - If client #6 expressed thoughts of suicidal ideation, staff would administer him his PRN medication of Hydroxyzine 25mg - On 7/13/23, client #6 became upset when staff attempted to wake him up to get ready to go to the day program - As a result of becoming upset, client #6 eloped from the facility and was missing for 16-18 hours - When client #6 was located, he expressed thoughts of suicidal ideation and was involuntarily committed at a local hospital for a week - After the 7/13/23 incident, the treatment team agreed to limit client #6's use of electronics at night because client #6 would "stay up all night" playing his game and didn't want to get up in the mornings - Client #6 attempted suicide on 9/27/23 by crushing and ingesting his Lithium pills - Client #6 admitted to "cheeking" his Lithium pills and saving them in a container that was kept hidden in his bedroom	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 112	Continued From page 12 - After 9/27/23, staff "take extra steps" when administering client #6 his medication to ensure he's doesn't "cheek" his medicine and staff conducted a weekly room search - Close monitoring meant having a "staff in the home" - There wasn't a specified time to check client #6, but "I would say every 30 minutes to an hour" Interview on 1/30/24 the QP reported: - Was responsible for developing the clients' treatment plans - Treatment plans were developed "once a year" and "updated" as needed - The strategies used for client #6 to prevent "cheeking" medications, to structure the use of his electronics, and decrease thoughts of suicidal ideation and threats of suicide were supposed to be in client #6's treatment plan but "I haven't included it in the PCP (person centered plan) yet" - "I mainly deal with goals in independent living" or clients "may have a social goal" - Client #6 didn't have a behavior support plan (BSP) so therefore client #6 didn't have any behavioral goals - There were no goals to address client #6's thoughts of suicidal ideation or threats of suicide because he had to "go through a psychiatrist to get a goal" or "have him suggest to put one (a goal) in place" - Didn't contact the psychiatrist to develop a goal for client #6 because client #6 "never" attempted suicide before Interview on 1/31/24 the Executive Director revealed: - The QP was responsible for developing and updating clients' treatment plans - Treatment plans were updated if there was a "significant change for a person (client)"	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 112	Continued From page 13 - Was unaware client #6's treatment plan didn't include the strategies to decrease thoughts of suicidal ideation and threats of suicide, or structure the use of client #6's electronics - Was unaware client #6's treament plan was not updated to include the strategies to prevent him from "cheeking" medications - "All of the services that are provided (to client #6) should be listed" in client #6's treatment plan - Client #6 was unable to receive a BSP due to "funding;" therefore, client #6 didn't have any "behavioral" goals for thoughts of suicidal ideation and threats of suicide - Legacy Human Services, LLC (Licensee) didn't have a psychologist to develop goals for thoughts of suicidal ideation and threats of suicide - Client #6 "never had a plan (BSP) for suicide because he (client #6) never had suicidal behavior" - Was never informed by client #6's guardian that client #6 made threats of suicide or had any attempts of suicide - Could not recall when she received client #6's psychological evaluation - "Not sure" what close monitoring meant because "I didn't write it...you can ask [QP]" This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 violation and must be corrected within 23 days.	V 112		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 113	Continued From page 14 contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143.	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 113	Continued From page 15	V 113		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure 1 of 3 audited client's (#6) record contained full documentation of services provided and progress towards the outcomes. The findings are:

Review on 1/23/24 of client #6's record revealed:
- Admitted 1/24/2020
- Diagnoses of Mild Intellectual Developmental Disorder, Autism Spectrum Disorder (Asperger's), Persistent Depressive Disorder, Posttraumatic Stress Disorder (PTSD), and Gender Dysphoria
- July - December 2023 progress notes all had the same summary: "[Client #6] ran away from group home on 7-13th-2023...he was missing for over 10 hours or more and was taking to the Hospital on that day for PTSD and Suicide and Anxiety feelings to [Local hospital] for 7 days."
- September - December 2023 progress notes all had the same summary: "[Client #6]...went to the Hospital on SEPTEMBER 28th 2023 for Suicide Attempt..."
- None of the progress notes provided information on whether or not client #6 verbalized threats of suicide or thoughts of suicidal ideation

Review on 1/24/24 of the facility's records revealed:
- Client #6's after visit hospital summary dated 7/20/23: "You (client #6) were admitted to [Local Hospital Behavioral Health] for symptoms of suicidal thoughts..."

Interview on 1/24/24 client #6 reported:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 113	Continued From page 16 - Was "depressed" and "not wanting to be alive anymore" - "Tried to commit suicide" - "Been thinking about it (suicide) all my life" - Cut his arm with broken glass and eloped on 7/13/23 - "Went to the hospital because I had thoughts to kill myself" on 7/13/23 - Attempted suicide 9/27/23 Interviews on 1/25/24 and 1/31/24 the Residential Manager reported: - Client #6 expressed thoughts of suicidal ideation, but "not often" - Client #6 would say "I feel like I want to kill myself" - Staff didn't document when client #6 expressed thoughts of suicidal ideation or made threats of suicide because client #6 didn't do it "often" - She was responsible for writing the clients' progress notes - She didn't include how often client #6 verbalized thoughts of suicidal ideation because "he didn't say it at the group home often" - Client #6 did have a ABC (antecedent, behavior, and consequence) data sheet, but staff didn't document when he verbalized thoughts of suicidal ideation or threats of suicide Interview on 1/30/24 the Qualified Professional (QP) reported: - The Residential Manager was responsible for writing the clients' progress notes - Client #6's thoughts of suicidal ideation and threats of suicide were documented on his ABC data sheet, but he needed to check with the Residential Manager because "He (client #6) may not have a ABC data sheet" - Planned to develop a ABC data sheet for	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 113	Continued From page 17 client #6 if he didn't already have one - He reviewed and signed off on the clients' progress notes, but he hadn't realized the Residential Manager hadn't documented client #6's thoughts of suicidal ideation in the progress notes Interview on 1/31/24 the Executive Director reported: - The Residential Manager was responsible for writing the clients' progress notes - The QP was responsible for overseeing the clients' progress notes - Client #6's thoughts of suicidal ideation and threats of suicide were supposed to be documented on a ABC data sheet - Was unaware that client #6's thoughts of suicidal ideation and threats of suicide were not documented on client #6's ABC data sheet or progress notes	V 113		
V 119	27G .0209 (D) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (d) Medication disposal: (1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion. (2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction.	V 119		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 119	Continued From page 18 (3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. (4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to dispose of medication affecting 1 of 3 audited clients (#6). The findings are: Review on 1/23/24 of client #6's record revealed: - Admitted 1/24/2020 - Diagnoses of Mild Intellectual Developmental Disorder, Autism Spectrum Disorder (Asperger's), Persistent Depressive Disorder, Posttraumatic Stress Disorder, and Gender Dysphoria - Physician's order dated 11/30/23 for Proair Inhale two puffs by mouth every 4 hours PRN (as needed) (Asthma/Wheezing) Observation 1/23/24 of client #6's medication bin revealed: - Proair Inhaler with an expiration date of 8/30/23 Interview on 1/24/24 client #6 reported: - Had an inhaler for "wheezing" due to a	V 119		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 119	Continued From page 19 previous cold - Didn't use the inhaler - Last used the inhaler "about a year ago" Interview on 1/24/24 staff #1 reported: - Client #6 hadn't used his inhaler - Didn't know the inhaler was expired - The Registered Nurse (RN) was responsible for disposing of medications Interview on 1/24/24 staff #2 reported: - Saw client #6's inhaler was expired, but she "can't remove (dispose) medications" - The RN was responsible for disposing the clients' medications - She "forgot to tell [RN] it (client #6's inhaler) was expired" Interview on 1/29/24 the RN reported: - Came to the facility and checked medications every three months - Checked for expired medications - Responsible for ensuring medications were discarded - Staff can dispose of medications "if they felt comfortable" - Some staff would "take care of it (medication), some will put it back until I come" - Two staff could dispose of the medication by taking the medications to the sheriff's office and discarding the medication in a secure medication box known as the "drug buster" - Was unaware client #6's inhaler had expired and was not disposed of - Staff could have disposed of the inhaler by "putting it in the trash" Interview on 1/24/24 the Residential Manager reported: - Was unaware client #6's inhaler had expired	V 119		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 119	Continued From page 20 - The RN was responsible for "overseeing" disposals - The RN came to facility every three months - Two staff could dispose of medications in a "thermal cup" or "flush" it down a commode Interview on 1/30/24 the Qualified Professional reported: - The RN was responsible for overseeing the medications in the facility Interview on 1/31/24 the Executive Director reported: - The RN and staff were responsible for discarding medications - Was unaware client #6's inhaler had expired and hadn't been discarded - Staff or the RN disposed of medications by returning it to the pharmacy or dissolving the medicine	V 119		
V 364	G.S. 122C- 62 Additional Rights in 24 Hour Facilities § 122C-62. Additional Rights in 24-Hour Facilities. (a) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-61, each adult client who is receiving treatment or habilitation in a 24-hour facility keeps the right to: (1) Send and receive sealed mail and have access to writing material, postage, and staff assistance when necessary; (2) Contact and consult with, at his own expense and at no cost to the facility, legal counsel, private physicians, and private mental health, developmental disabilities, or substance abuse professionals of his choice; and (3) Contact and consult with a client advocate if	V 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 364	Continued From page 21 there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each adult client may exercise these rights at all reasonable times. (b) Except as provided in subsections (e) and (h) of this section, each adult client who is receiving treatment or habilitation in a 24-hour facility at all times keeps the right to: (1) Make and receive confidential telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over therapies; (3) Communicate and meet under appropriate supervision with individuals of his own choice upon the consent of the individuals; (4) Make visits outside the custody of the facility unless: a. Commitment proceedings were initiated as the result of the client's being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the respondent was found not guilty by reason of insanity or incapable of proceeding; b. The client was voluntarily admitted or committed to the facility while under order of commitment to a correctional facility of the Division of Adult Correction of the Department of Public Safety; or c. The client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; A court order may expressly authorize visits otherwise prohibited by the existence of the conditions prescribed by this subdivision; (5) Be out of doors daily and have access to	V 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 364	Continued From page 22 facilities and equipment for physical exercise several times a week; (6) Except as prohibited by law, keep and use personal clothing and possessions, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; (7) Participate in religious worship; (8) Keep and spend a reasonable sum of his own money; (9) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes; and (10)Have access to individual storage space for his private use. (c) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-57 and G.S. 122C-59 through G.S. 122C-61, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to have access to proper adult supervision and guidance. In recognition of the minor's status as a developing individual, the minor shall be provided opportunities to enable him to mature physically, emotionally, intellectually, socially, and vocationally. In view of the physical, emotional, and intellectual immaturity of the minor, the 24-hour facility shall provide appropriate structure, supervision and control consistent with the rights given to the minor pursuant to this Part. The facility shall also, where practical, make reasonable efforts to ensure that each minor client receives treatment apart and separate from adult clients unless the treatment needs of the minor client dictate otherwise. Each minor client who is receiving treatment or habilitation from a 24-hour facility has the right to: (1) Communicate and consult with his parents or guardian or the agency or individual having legal custody of him;	V 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 364	Continued From page 24 (8) Have access to individual storage space for the safekeeping of personal belongings; (9) Have access to and spend a reasonable sum of his own money; and (10)Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes. (e) No right enumerated in subsections (b) or (d) of this section may be limited or restricted except by the qualified professional responsible for the formulation of the client's treatment or habilitation plan. A written statement shall be placed in the client's record that indicates the detailed reason for the restriction. The restriction shall be reasonable and related to the client's treatment or habilitation needs. A restriction is effective for a period not to exceed 30 days. An evaluation of each restriction shall be conducted by the qualified professional at least every seven days, at which time the restriction may be removed. Each evaluation of a restriction shall be documented in the client's record. Restrictions on rights may be renewed only by a written statement entered by the qualified professional in the client's record that states the reason for the renewal of the restriction. In the case of an adult client who has not been adjudicated incompetent, in each instance of an initial restriction or renewal of a restriction of rights, an individual designated by the client shall, upon the consent of the client, be notified of the restriction and of the reason for it. In the case of a minor client or an incompetent adult client, the legally responsible person shall be notified of each instance of an initial restriction or renewal of a restriction of rights and of the reason for it. Notification of the designated individual or legally responsible person shall be documented in writing in the client's record.	V 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 364	Continued From page 25	V 364		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure the restriction of 1 of 3 client's (#6) access to personal property had a written statement detailing the reason for the restriction and failed to review the restriction as required. The findings are:

Review on 1/24/24 of the facility's records revealed:
- A meeting summary dated 10/20/23: "[Client #6] will turn off all electronics devices (hand held game system and IPad) nightly at 9:00pm"
- An electronic plan data sheet for client #6 that was implemented on 7/21/23 for the use of daily documentation of "Structure use of Electronics" and provided the following instructions: "[Client #6] is very attached to his electronic games, and his IPad...At 9pm staff will prompt [client #6] to turn in his electronics to the office."
- No documentation from client #6's guardian regarding turning in his electronics at night

Interview on 1/24/24 client #6 reported:
- Had to give staff his electronics every night "so I won't stay up late"
- "Don't mind" turning his electronics in at night

Interviews on 1/30/24 and 1/31/24 the Qualified Professional (QP) reported:
- The treatment team agreed to limit client #6's use of his electronics at night after he was involuntarily committed on 7/13/23
- Client #6 turned in his electronics to staff every night
- Didn't know he had to write a written

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 364	Continued From page 26 statement detailing the reason for the restriction or review the restriction every 7 days - Thought the letter from client #6's guardian could be used as the written statement detailing the reason for the restriction Interview on 1/31/24 the Executive Director reported: - The treatment team agreed to limit client #6's use of his electronics at night - Client #6 gave staff his electronics every night - Client #6's guardian requested for client #6 to turn in his electronics every night - Didn't "think" client #6 turning in his electronics was a rights restriction since the guardian requested it - Wasn't aware the facility was restricting client #6's rights because the facility was "honoring the guardian's request" to limit client #6's use of his electronics - Considered the letter provided by client #6's guardian representative as the written statement for detailing the reason for the rights restriction - Didn't think the rights restriction needed to be reviewed every 7 days because the "we're (Legacy Human Service, LLC) not restricting client #6's rights, his guardian is" This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 violation and must be corrected within 23 days.	V 364		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 512	Continued From page 27 (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by: Based on record review and interview, 1 of 3 audited paraprofessionals (#2) neglected 1 of 3 audited clients (#6). The findings are: Review on 1/23/24 of client #6's record revealed: - Admitted 1/24/20 - Diagnoses of Mild Intellectual Developmental Disorder, Autism Spectrum Disorder (Asperger's), Persistent Depressive Disorder, Posttraumatic Stress Disorder, History of self harm and suicidal ideation, and Gender Dysphoria - A Psychological Evaluation with the latest date of evaluation listed as 2/13/18: "Suicide	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 512	Continued From page 28 threats and behaviors occur after he (client #6) gets upset when he does not get his way...His biological mother...reportedly blamed him for things...He stills idealizes her and seems to follow suit in self-blame when he is upset, which then results in self-harm and/or suicidal ideations." Review on 1/24/24 of staff #2's personnel record revealed - Hired 9/16/20 - Medication Administration training certificate dated 9/12/23 - Cardiopulmonary Resuscitation (CPR) and first aid certificate dated 9/16/22 Review on 1/29/24 of the facility's Medication Administration PowerPoint presentation training (no date) revealed the following topics: - Signs and symptoms of illnesses - Signs and symptoms of lithium toxicity Review of 1/24/24 of the facility's Emergency Preparedness Plan for Medical Emergencies/Serious Illness or Injury revealed: - "In the event of a serious injury or illness to any individual of the group home, the immediate concern is to assist the injured or sick person in obtaining treatment...If the need is critical, the group home manager or designee will immediately have someone call 911 while he or she stays with the individual..." Review on 1/25/24 of a level II incident report written by staff #2 and dated 9/27/23 revealed: - "I called [client #6] 2 times for Dinner he didn't come so I went to his room and he was looking like he could barely keep his eyes open. I called [Residential Manager] to ask her can she come to the group home. I gave him his PRN (as needed) (Hydroxyzine 25 milligrams (mg)) and she told me	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 512	Continued From page 29 if I need her to call her and I immediately call back in 5 mins (minutes) and she said I am on my way. When she arrived we both went in his room we was told by the 911 lady to hold his head back then put him in the floor to begin CPR until the emergency squad arrived then they took over..." Review on 1/25/24 of client #6's Emergency Medical Service (EMS) run sheet dated 9/27/23 revealed: - "Pt (patient) is found on floor of bedroom with staff performing CPR. Pt has white powdery substance in his mouth, staff advised they had given him medication just prior to him becoming unresponsive." - "Dispatched by 911 ref (reference) unresponsive. When enroute central advised pt has possibly in cardiac arrest. On arrival CPR was in progress by staff....Staff advised that pt was starting to 'act up' so they administered his PRN medication (Hydroxyzine 25 milligram (mg)) for agitation, and he became unresponsive shortly after. Staff state that pt is known to try self-harm and may have taken additional medication that may not be his..." Review on 1/25/24 of an investigation conducted by the Executive Director dated 9/29/23 revealed: - "Staff (staff #2) reported to [Residential Manager] that she administered [client #6]'s 25mg of Hydrazine PRN and after calling him for dinner twice, went to check on him, and found him a little responsive on his bed...[Residential Manager] stated she was at the house within 12 minutes...the doctor from [local hospital] called... [client #6] tox (toxicology) screening came back and he had Lithium Toxicity" Interview on 1/24/24 client #6 reported: - Was "depressed" and "not wanting to be alive	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 512	Continued From page 30 anymore" - "Tried to commit suicide" - "Tried all my life" - "OD'd (overdosed) off Lithium" - "Snuck" his Lithium in his room by holding it in his mouth after receiving his medications in the facility - Took the Lithium pills around 4pm - Didn't recall staff #2 coming in his room to get him for dinner Interview on 1/25/24 staff #2 reported: - Was trained in CPR, first aid and medication administration - Knew that "you can tell by looking at a person" if they were acting outside of their normal behavior and knew to "call 911" in emergencies - On 9/27/23, client #6 got an "attitude" he didn't have access to client #1's WiFi - Around 6:30pm, she called client #6 twice to eat dinner and he didn't come She went to his room and asked client #6 what was wrong and he said "nothing" - Gave him his PRN medication (Hydroxyzine 25mg) - Client #6 "didn't look right...just staring (at her) and mumbling...he never got up (out of bed)" - Client #6 "talked awhile (mumbling) and stopped...just staring" - "It (client #6 behavior) was different from his norm (normal behavior) because he's happy and talkative" - Called the Residential Manager because she thought client #6 was "acting out (behavior)" - Called the Residential Manager back when she saw client #6's "eyes roll back in his head," he was "making a grunting noise" and was no longer "speaking" - Knew client #6's "eyes rolling back" and "grunting noises" wasn't "normal"	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 512	Continued From page 31 - The Residential Manager "got here (the facility) in five minutes" after the second phone call - Client #6 was unresponsive when she and the Residential Manager went into his room - Stayed in the room with client #6, but she could not recall when client #6 went unconscious - The Residential Manager called 911 when client #6's arm "flopped" down off the bed after she touched him - Knew to call 911, but the Residential Manager was "on the way" and "I knew she (Residential Manager) would call (911)" - She had started performing CPR compressions before the Residential Manager called 911 - Client #6 had a pulse but was "gasping" for breath Interview on 1/29/24 the CPR Instructor reported: - Was a CPR and first aid instructor for "30 plus years" - Taught CPR and first aid for Legacy Human Services, LLC (Licensee) - Staff #2 completed his CPR and first aid class 9/16/22 - "I teach staff to recognize a crisis and get help (call 911) as soon as possible," and "follow their policy and procedure for emergency response" - Staff should "make a patient assessment and if there is no protocol, call 911" - "Anytime they (clients) are not responding, call 911" Interview on 1/29/24 the Registered Nurse reported: - Was a nurse consultant for Legacy Human Services, LLC (Licensee) - Trained staff #2 on medication administration	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 512	Continued From page 32 and signs and symptoms of illnesses - She trained staff #2 on identifying signs and symptoms of lithium toxicity - "Staff knows the residents better than anyone. If there is something different with a client, pay attention, document, and if you don't think you can handle the situation then call 911 and have them come and assess" the clients Interviews on 1/23/24 and 1/25/24 the Residential Manager reported: - On 9/27/23, staff #2 called her and said client #6 was "crying" and saying "he (client #6) didn't feel right" - Spoke with client #6 on the phone and he was upset but she "couldn't understand him" - Staff #2 told her that client #6 asked for his PRN medication and asked "when [client #1] was coming back" - Staff #2 said she thought client #6 was "acting out" because he wanted to use client #1's WiFi - Staff #2 told her that client #6 returned to his bedroom - Staff #2 said she "called him (client #6) for dinner and he didn't respond" - Staff #2 said she "called him again and he (client #6) didn't respond so she (staff #2) went to the room and said he was 'looking out of it'" - Staff #2 "called me back and said 'something is wrong with [client #6]" - Staff #2 "came back to the staff office and she (staff #2) was giving out clients' meds (medications), and by that time I had arrived" to the facility - She went into client #6's room and he was "slumped over" - "[Client #6] wasn't responding...had foam coming out of his mouth and his eyes won't looking right"	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 512	Continued From page 33 - She called 911 and dispatch instructed her to lay client #6 flat on the floor and there was "no movement" from client #6 - Staff #2 began CPR - When she relieved staff #2 from performing CPR and while she was doing chest compressions client #6 "took a breath" - Lived "about 9 to 10 minutes" away from the facility in a neighboring city - Could not recall how much time had passed from when she received the second call from staff #2 to when she arrived at the facility - "Don't know why [staff #2] didn't call 911" - "She (staff #2) thought he (client #6) was just laying down and he was sleep" - "Don't know why she (staff #2) didn't call 911 after she said client #6 'looked out of it'" - She "spoke with her (staff #2) afterwards and told her "that she needed to call 911 first when clients weren't acting right" Interviews on 1/25/24 and 1/31/24 the Executive Director reported: - Client #6 ingested his Lithium pills on 9/27/23 - Staff #2 called both 911 and the Residential Manager - Was unaware the Residential Manager called 911 on 9/27/23 - Staff #2 "didn't know what was wrong with him (client #6)" and she "called [Residential Manager] to assess the situation and determine if 911 was needed" - "[Staff #2] stayed with [client #6] the whole time" - Didn't know why staff #2 didn't call 911 "you're going to have to ask her" - Investigated client #6's suicide attempt on 9/27/23 and "I did not find it as neglect" - "No one knew that he (client #6) had overdosed until months later"	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 512	Continued From page 34 - "Don't agree that [staff #2] neglected [client #6]" - "We (Legacy Human Services, LLC) saved his (client #6's) life" - "Usually when there's a positive outcome it doesn't matter" who called 911 Review on 1/25/24 of a Plan of Protection dated 1/25/24 and written by the Executive Director revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? -Today, 1/25/24, all staff at the Oxford Group Home will receive inservice training on the medical emergency policy for calling 911. -Within 2 weeks, [staff #2] will receive CPR/First Aid by 2/8/2024. Describe your plans to make sure the above happens. Executive Director will give a directive to the Residential Manager to complete the inservice today. The Executive Director will schedule a CPR/First Aid Class prior to 2/8/24 for [staff #2]." Client #6 had a diagnoses of Mild Intellectual Developmental Disorder, Autism Spectrum Disorder Asperger's, Persistent Depressive Disorder, Posttraumatic Stress Disorder and history of self harm and suicidal thoughts. Staff #2 did not call 911 when she observed client #6's in his bedroom with his eyes rolling back in his head, making grunting noises, and was no longer speaking. Staff #2 called the Residential Manager to the facility, but did not immediately seek assistance from EMS as trained. Staff #2 waited for the Residential Manager to arrive at the facility to call 911, which resulted in a 12 minute delay. Upon her arrival, the Residential Manager found client #6 unresponsive, called 911, and was directed by 911 to perform CPR. This deficiency constitutes a Type A1 rule violation for serious	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-062	A. BUILDING: _____ B. WING _____	R 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GROUP HOME	605 NORTH COUNTRY CLUB DRIVE OXFORD, NC 27565

(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 512	Continued From page 35 neglect and must be corrected within 23 days.	V 512		

Legacy Human Services, Inc.

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

February 20, 2024

Mental Health Licensure and Certification Section

NC Department of Health and Human Services

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 Type A1 Administrative Penalty and the standard level deficiencies cited at the Oxford Group Home, Located at 605 N. Country Club Drive, Oxford, NC 27565. This is in conjunction with MHL #: 039-062.

You shall find upon return that all deficiencies cited have been addressed globally and the correction has been made prior to the correction date of February 23, 2024. 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,

Jacinta Johnson

Executive Director

ASPIRE to Excellence® carf ACCREDITED

Plan of Correction – Oxford

Date of Correction: February 23, 2024

Deficiency Cited: V108: 27G.0202 Personnel Requirements. Based on record reviews and interviews, the facility failed to ensure that staff had training to meet MH/DD/SA needs of the client.

Provider's Plan of Correction: Legacy Human Services, Inc. will ensure that each staff member is trained in client specific needs including Mental Health Signs and Symptoms. The Executive Director has reached out on 2/9/2024 to VAYA Health and scheduled "Question, Persuade, Refer (QPR) Suicide Prevention Training" for the earliest time available, which is 2/26/2024 from 1pm – 3pm. This training is mandatory for all Direct Support Professionals, Residential Manager, and QP of the Oxford Group Home.

Responsible Parties: Direct Support Professionals, Residential Manager, QP, and Executive Director

Correction Date: 2/23/2024

Deficiency Cited: V109: 27G. 0203 Privileging / Training Professionals. The facility failed to ensure the QP demonstrated the knowledge, skills and abilities required by the population served and educated staff on the enforcement of individuals' rights.

Provider's Plan of Correction: Legacy Human Services, Inc. will ensure that the QP meets his job description to "assess training needs, coordinate the orientation training and on-going and in-service training for direct care staff". Effective 1/31/2024, all guardian requested structured plans will no longer be honored. Restrictions of rights, even those imposed by guardians, will be reviewed at a PCP meeting and evaluated for necessity. The QP will participate in ongoing clinical training to address gaps in skillset including Mental Health issues which are documented. The Executive Director will complete a QP Core Competency Checklist with the QP to determine strengths and weaknesses, and seek support from MCOs, NC Medicaid, and NC DHHS resources to align training to bridge those gaps.

Responsible Parties: QP and Executive Director.

Correction Date: 2/23/2024 and ongoing

Deficiency Cited: V112: 10A NCAC 27G.0205. Assessment and Treatment / Habilitation or Service Plan. The facility failed to develop and implement goals and strategies to address client's needs.

Provider's Plan of Correction: Legacy Human Services, Inc. will ensure that each client receives a current and relevant Person-Centered Plan inclusive of revisions stemming from hospitalizations and changes in diagnosis and needs. Upon discharge from a psychiatric hospitalization, the team will meet to update the PCP plan to implement the diagnosis, signs and symptoms, updates to crisis plan, new services such as CST, new goals and identifying needs for which services may not be available, such as Behavior Support Plan, and how these changes will be addressed. For client [redacted] the PCP was updated on 2/5/2024.

Responsible Parties: Residential Manager, QP, Treatment Team, and Executive Director

Correction Date: 2/23/2024

Deficiency Cited: V113: 10A NCAC 27G. 0206. Client Records. The facility failed to ensure that the client record contained full documentation of services provided and progress towards the outcomes.

Provider's Plan of Correction: Legacy Human Services, Inc. will assure that ABC data for targeted behavioral data collection will be documented in the progress note. The Residential Manager and the QP will work together to make sure that the notes reflect all data available.

Responsible Parties: Residential Manager and QP

Correction Date: 2/23/2024

Deficiency Cited: V119: 27G.0209. Medication Requirements. The facility failed to assure that all medications are disposed of in a manner that guards against diversion or accidental ingestion.

Provider's Plan of Correction: Legacy Human Services, Inc. will ensure that all outdated medications or discarded medications are disposed of based on the agency's approved disposal policy. Staff will receive an additional In-Service to alert them of the disposal requirements.

Responsible Parties: Residential Manager, QP, RN, and Executive Director

Correction Date: 2/23/2024

Deficiency Cited: V364: 122C – 62. Additional Rights in 24-Hour Facilities. The facility failed to ensure that the restriction of client's individual property had a written statement detailing the reason for the restriction and failed to review the restriction as required.

Provider's Plan of Correction: Effective 1/31/2024, the agency will no longer honor guardian's requests for restrictions without a PCP meeting to discuss the reasoning, the time limitations,

and documenting every 7 days the necessity for the restriction. For client [redacted] those restrictions were lifted immediately on 1/31/2024 and discussed at PCP revision meeting on 2/5/2024.

Responsible Parties: Residential Manager, QP, and Executive Director

Correction Date: 1/31/2024

Deficiency Cited: V512: 10A NCAC 27D .0304. Protection from Harm, Abuse, Neglect or Exploitation. The agency staff failed to recognize and assess the crisis on 9/27/2023 and failed to call 911 before calling the supervisor for assistance in assessing the situation.

Provider's Plan of Correction: The agency staff will accurately recognize and assess a crisis, and "when in doubt call 911". The Plan of Protection will be implemented completely including immediate In-Service Training for all staff regarding calling 911. The staff involved in the crisis will receive CPR/FA class again on 2/2/2024. All staff of the home, including management and QP will attend a Suicide Prevention and Awareness Class sponsored by VAYA at the earliest scheduled date that is available which is 2/26/2024.

Responsible Parties: Direct Support Staff, Residential Manager, QP, and Executive Director

Correction Date: 2/23/2024

Provider Signature: _____ EXECUTIVE DIRECTOR

2/20/2024