STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL091-118	A. BUILDING: _____ B. WING _____	R 03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VANCE ADULT GROUP HOME	941 HWY 158 BY PASS HENDERSON, NC 27536

(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, complaint and follow up survey was completed on 3/26/25. The complaint was unsubstantiated (Intake #NC00228089). Deficencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 5 and has a current census of 4. The suvey sample consisted of 2 current clients and 1 former client.	V 000	See Attached Plan of Connection	
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter	V 111		

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V 111	Continued From page 1 referred to as the "plan," strategies to address the client's presenting problem shall be documented.	V 111		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure an admission assessment was completed for 1 of 2 audited current clients (#2) and 1 of 1 former client (FC #5). The findings are:

Review on 3/18/25 Client #2's record revealed:
- Admitted: 4/12/2019
- Diagnoses: Mild Intellectual Disabilities (IDD), Generalized Anxiety Disorder, Major Depressive Disorder, Obesity, Allergic Rhinitis
- No documentation of an admission assessment

Review on 3/18/25 FC #5's record revealed:
- Admitted: 5/11/22
- Diagnoses: Epilepsy, Hypertension, Type II Diabetes, Moderate IDD, Morbid Obesity, and Vitamin D Deficiency
- Discharged: 3/3/25
- No documentation of an admission assessment

Interview on 3/24/25 the Qualified Professional (QP) reported:
- Been the QP since 2014

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V 111	Continued From page 2 - Was responsible for Independent Living Assessments (IDLA) at admission - Hadn't done any admission assessments since he had been employed at the facility - He had seen some admission assessments and they were more detailed than the IDLA but he hadn't done one - The Executive Director (ED) never told him that he had to do admission assessments Interview on 3/25/25 the ED reported: - The QP was responsible for admission assessments - The application for admission as well as the IDLA checklist had all the information on it for admission - The IDLA checklist was their admission assessment - When the "Local Management Entity (LME)" switched, they didn't require them to do a "full" admission assessment - When the new LME took over, she believed "I'm going to guess that it fell through the cracks with all the changes" Further interview on 3/26/25 the ED reported: - "it just fell through the cracks" but she would make sure they started doing the admission assessments again	V 111		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs.	V 118		

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V 118	Continued From page 3 (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure the medications were administered on the written order of a physician affecting 2 of 2 audited current clients (#2, #4). The findings are: A. Review on 3/18/25 of Client # 2's record revealed: - Admitted: 4/12/19	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 118	Continued From page 4 - Diagnoses: Mild Intellectual Disabilities, Generalized Anxiety Disorder, Major Depressive Disorder, Obesity, and Allergic Rhinitis - FL2 dated 2/6/25 revealed: - Hydroxyzine Pamoate (Pam) 25 milligrams (Mg) Capsule (Cap), as needed (PRN) (Anxiety) - Sudogest 12 hour 120 Mg Cap, PRN (Allergic Rhinitis) Observation on 3/18/25 at approximately 1:10pm of Client # 2's medication box revealed: - Hydroxyzine Pam had a discard date of 10/4/24 - Sudogest had a discard date of 8/21/24 - No other Hydroxyzine or Sudogest was in the facility Interview on 3/18/25 with the Residential Manager (RM) stated: - She was responsible for checking medications and ordering refills - Checked for expired medications every time she went in the medication drawer - Hydroxyzine is a PRN that came in a pill-pack - When the guardian took Hydroxyzine for home visits, he would take them out of the pill-pack and put them in a medication bottle, and that was how he returned it to the facility - The medication bottle had Client # 2's label, but had a discard date of 10/4/24 - Discussed with the guardian to stop doing that, and he wouldn't - Client # 2 went on a home visit at least 3 times a month - She had just returned back to the facility from being on a home visit for 1 1/2 weeks B. Review on 3/18/25 of Client #4's record revealed:	V 118		

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	MHL091-118	A. BUILDING: _____ B. WING _____	R 03/26/2025

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V 118	Continued From page 5 - Admitted: 3/1/10 - Diagnoses: Moderate IDD, Congestive Heart Failure, Obesity, and Sleep Apnea - FL2 dated 2/26/25 revealed: - Ventolin HFA (hydrofluoroalkane) Inhaler, PRN (breathing difficulties) Observation on 3/18/25 at approximately 1:10pm of Client # 4's medication box revealed: - Ventolin HFA had a discard date of 7/26/24 - No other Ventolin HFA was in the facility Interview on 3/18/25 with the RM stated: - She was responsible for checking medications and ordering refills - Checked for expired medications every time she went in the medication drawer - Client # 2's inhaler fell in the back of the medication cart - She did not know that it had expired - Client # 2 hadn't used it in a while - She would call to get it discontinued (d/c) Observation on 3/18/25 at approximately 1:25pm of the RM calling the pharmacist revealed: - The pharmacist said that inhaler was over a year old and they would not fill it Observation on 3/18/25 at approximately 1:30pm of the RM calling the doctor revealed: - The doctor's office was going to d/c the inhaler and would fax over the d/c order Interview on 3/20/25 the Qualified Professional (QP) reported: - The facility nurse "mainly" did the MARs and medication checks - He did "spot checks" when he visited the facility to make sure the MARs had been signed off on	V 118		

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V 118	Continued From page 6 Interview on 3/20/25 the Executive Director (ED) reported: - The QP visited the group home monthly to do a documentation check - Medications were one thing the QP needed to check in case the staff and Residential Manager missed something - There was a checklist that included medication checks that the QP used when he visited the facility - Consultant nurses that visited the facility also checked the medications and MARs Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician.	V 118		
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. (3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled	V 119		

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V 119	Continued From page 7 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 record reviews, observations and interviews the facility failed to dispose of medications in a manner that guards against diversion or accidental ingestion affecting 2 of 2 audited current clients (#2, #4). The findings are: Review on 3/18/25 of Client # 2's record revealed: - Admitted: 4/12/19 - Diagnoses: Mild Intellectual Disabilities, Generalized Anxiety Disorder, Major Depressive Disorder, Obesity, and Allergic Rhinitis - FL2 dated 2/6/25 revealed: - Hydroxyzine Pamoate (Pam) 25 milligrams (Mg) Capsule (Cap), as needed (PRN) (Anxiety) - Sudogest 12 hour 120 Mg Cap, PRN (Allergic Rhinitis) Observation on 3/18/25 at approximately 1:10pm of Client # 2's medication box revealed: - Hydroxyzine Pam had a discard date of 10/4/24	V 119		

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V 119	Continued From page 8 - Sudogest had a discard date of 8/21/24 Review on 3/18/25 of Client #4's record revealed: - Admitted: 3/1/10 - Diagnoses: Moderate IDD, Congestive Heart Failure, Obesity, and Sleep Apnea - FL2 dated 2/26/25 revealed: - Ventolin HFA (hydrofluoroalkane) Inhaler, PRN (breathing difficulties) Observation on 3/18/25 at approximately 1:10pm of Client # 4's medication box revealed: - Ventolin HFA had a discard date of 7/26/24 Interview on 3/18/25 with the Residential Manager stated: - They used a drug buster which was a liquid that melted down the pills - They used two staff to witness the pills being melted down - All other medications such as inhalers were returned back to the pharmacy	V 119		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in	V 290		

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V 290	Continued From page 9 the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that a client was capable of remaining in the community without supervision affecting 1 of 1 former client (FC #5). The findings	V 290		

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V 290	Continued From page 10 are: Review on 3/18/25 of FC # 5's record revealed: - Admitted: 5/11/22 - Diagnoses: Epilepsy, Hypertension, Type II Diabetes, Moderate IDD, Morbid Obesity, and Vitamin D Deficiency - Discharged: 3/3/25 Interview on 3/19/25 FC #5's guardian reported: - She was told that the staff took FC #5 to the hospital and would leave her and came back to pick her up when the hospital called them Interview on 3/25/25 the Residential Manager (RM) reported: - When FC #5 went to the hospital, staff #1 went in to let the hospital know what was going on - Staff #1 would then leave and the hospital would call when FC #5 was ready for discharge - There was only 1 person on shift at a time so you couldn't leave the clients and be in the hospital with FC #5 - It was always told to them that they didn't get paid for being at the facility and the hospital - Staff would leave their detailed contact information with the hospital and then they would leave - They had never been at the hospital the whole time a client was in the emergency room (ER) unless there was a surgical procedure or something of that "magnitude" - "But just to say that someone is just sitting at the ER I have never seen that" Interview on 3/25/25 the Executive Director (ED) reported: - Every time that FC #5 went to the ER, she was not sure that staff stayed with her the entire	V 290		

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	MHL091-118	A. BUILDING: _____ B. WING _____	R 03/26/2025

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V 290	Continued From page 11 time because they didn't have the staffing to be able to stay with FC #5 - She had been told that because the hospital has Medicaid services they cannot have 2 Medicaid services happening at once because that was "double dipping" - That was why they didn't stay at the hospital along with not having the "manpower" - "I don't know that staff stay with her (FC #5) the whole time. Sometimes they can sometimes they can't" - "We don't always have the staff" - "We don't have staff just sitting around to take someone to the hospital" Further interview on 3/26/25 the ED reported: - "We will have to figure out something but I don't know what because it was a courtesy when we stayed at the hospital with clients"	V 290		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL091-118	A. BUILDING: _____ B. WING _____	R 03/26/2025

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V 367	Continued From page 12	V 367		

information:
(1) reporting provider contact and identification information;
(2) client identification information;
(3) type of incident;
(4) description of incident;
(5) status of the effort to determine the cause of the incident; and
(6) other individuals or authorities notified or responding.
(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:
(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information required on the incident form that was previously unavailable.
(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:
(1) hospital records including confidential information;
(2) reports by other authorities; and
(3) the provider's response to the incident.
(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death

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V 367	Continued From page 13 immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report all Level II incidents to the Local Management Company/Managed Care Organization (LME/MCO) within 72 hours of becoming aware of the incident. The findings are: Review on 3/18/25 of Former Client (FC) # 5's record revealed:	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL091-118	A. BUILDING: _____ B. WING _____	R 03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VANCE ADULT GROUP HOME	941 HWY 158 BY PASS HENDERSON, NC 27536

(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 367	Continued From page 14 - Admitted: 5/11/22 - Diagnoses: Epilepsy, Hypertension, Type II Diabetes, Moderate IDD, Morbid Obesity, and Vitamin D Deficiency - Discharged: 3/3/25 Review on 3/17/25 of the Incident Response Improvement System (IRIS) revealed: - No entries since December 2024 Review on 3/18/25 of the facility's incident log book revealed: - No incident report completed for FC #5 falling and needing 911 assistance on 3/3/25 Interview on 3/18/25 the Residential Manager (RM) reported: - FC #5 was being discharged from the facility on 3/3/25 - Her guardian and her guardian's niece were at the facility to pick her up - While the guardian was signing discharge paperwork in the kitchen, FC #5 fell while with the guardian's niece in the living room - The guardian told FC #5 to get up and FC #5 stated that she couldn't - The RM told the guardian to call 911 to see if they could send emergency medical services (EMS) to the facility to help get FC #5 up off the floor - The fire trucks came with 2 firefighters, and they tried to get her up but FC #5 was being resistant and they didn't want to keep pulling on her - More fire trucks came, 6 firefighters total, and they eventually got her up and put her on her rollator - The firefighters kept trying to tell FC #5 to lift her feet but her feet kept dragging as if she didn't want them to move her	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL091-118	A. BUILDING: _____ B. WING _____	R 03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VANCE ADULT GROUP HOME	941 HWY 158 BY PASS HENDERSON, NC 27536

(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 367	Continued From page 15 - No incident report was done but she did tell the Executive Director (ED) about the fire trucks coming to the facility Interview on 3/20/25 the Qualified Professional (QP) reported: - He was made aware of incidents in the facility - He did not do IRIS - The ED did the IRIS reports Interview on 3/25/25 the ED reported: - She was responsible for completing IRIS - She was notified by phone call or text depending on the severity of the incident - She did not do an IRIS report for FC #5 - She did not know that she needed to do one - She got confused on when to do IRIS	V 367		

Plan of Correction – Vance Adult

Date of Correction: May 25, 2025

Deficiency Cited: V111: 10A NCAC 27G.0203. Assessment / Treatment / Habilitation Plan. The agency failed to document the Admissions Assessment for 2 of the 5 clients in the home.

Provider's Plan of Correction: Legacy Human Services, Inc. will ensure that each client has an admissions assessment completed. The Executive Director, Residential Manager and Qualified Professionals will inventory the charts to ascertain who is missing an admissions assessment. The Qualified Professional will complete an admissions assessment for each one missing no later than May 25, 2025. When reviewing the chart at Quality Improvement Team meetings, an admissions assessment will be added as something to check for. All admissions assessments will be placed in a plastic sleeve so that they are never removed when thinning the charts.

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

Correction Date: 5/25/2025

Deficiency Cited: V118: 10A NCAC 27G.0209 Medication Requirements. The agency failed to ensure medications were administered in the written order of a physician in that 2 of 2 client's medications were expired.

Provider's Plan of Correction: Legacy Human Services, Inc. will assure that each client receives their medications as prescribed and that the medications are checked regularly by the Residential Manager, QP, and RN to match up the doctor's orders and make sure that no medications in the home are expired. The Residential Manager, QP and RN will receive additional Inservice training on the thoroughness of Supervision visits and going through the medications for accuracy.

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

Correction Date: 5/25/2025

Deficiency Cited: V119: 10A NCAC 27G. 0209 Medication Disposal. The agency failed to ensure medications that were expired were disposed of properly based on the policy of the agency.

Provider's Plan of Correction: Legacy Human Services, Inc. will ensure that all medications which are expired are disposed of based on the policy of the agency which is to use the Drug

Buster product or return to the pharmacy. The QP will Inservice the Residential Manager and the RN on these practices and check monthly during supervisions that the medications are disposed of as per policy.

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

Correction Date: 5/25/2025

Deficiency Cited: V290: 10A NCAC 27G . 5602 Staffing. The agency failed to provide staffing at the hospital when a client was receiving Medicaid services at the emergency room or hospital.

Provider's Plan of Correction: Legacy Human Services, Inc. will address the requirement of the State to provide staffing at the hospital on a case-by-case basis whereas clients will have unsupervised time documented on their PCP if they are capable of being in the community or hospital without supervision, because they understand safety rules, and can self-advocate. In the event that they cannot, then the Residential Manager will be required to accompany them to the hospital. In the absence of the Residential Manager, it will be the on-call personnel. The management team will be In-Serviced on this new requirement by the Qualified Professional and Executive Director.

Responsible Parties: QP, Residential Manager, and Executive Director

Correction Date: 5/25/2025

Deficiency Cited: V367: 10A NCAC 27G.0604. Incident Reporting. The agency failed to report all level II incidents, except deaths, which occur during the provision of billable services or while the consumer is on the providers' premises. In this instance, a client has been discharged and the guardian called 911 for assistance getting her in the car.

Provider's Plan of Correction: Legacy Human Services, Inc. will make this correction as we were unaware that even if the guardian called 911, we were responsible for an IRIS report, even though the client had been discharged. In the future, an IRIS report will be filed on this type of issue. As a backup, the Incident Report Form will be revised to include notification to IRIS, so if the Executive Director missed it, the Quality Improvement Team would catch it under monthly incident report reviews.

Responsible Parties: All managers, QP, and Executive Director, members of the QI committee

Correction Date: 5/25/2025

Provider Signature: _____ QP/CO

Division of Health Service Regulation
Mental Health Licensure and Certification Section
Rule Violation and Client/Staff Identifier List

Facility Name: Vance Adult Group Home MHL Number: 091-118
Exit Date: 3/26/2025 Surveyor(s): [redacted]

EXIT PARTICIPANTS: [redacted] **Executive Director**

COVID NOTIFICATION: In the event a COVID positive case is identified within 48 hours of a DHSR survey – the provider or DHSR should notify the other entity to prevent possible continued exposures.

Rule Violation/Tag #/Citation Level: **10A NCAC 27G .0205 /Assessment and Treatment/Habilitation or Service Plan /V111/standard**

Rule Violation/Tag #/Citation Level: **10A NCAC 27G .0209/ Medication Requirements /V118/ standard**

Rule Violation/Tag #/Citation Level: **10A NCAC 27G .0209/Medication Requirements /V119/ standard**

Rule Violation/Tag #/Citation Level: **10A NCAC 27G .5602/Supervised Living- Staff /V290/ standard**

Rule Violation/Tag #/Citation Level: **10A NCAC 27G .0604 /Incident Reporting Requirements /V367/ standard**

Client & Staff Identifier List
(Indicate staff title or number beside each name)

Client # [redacted]
Client #
Client #
Client #
Former Client #

Executive Director: [redacted]
Residential Manager:
QP:

Staff # 1 [redacted]

CITATION LEVEL: Number of days from survey exit for citation correction
Standard = 60 days **Recite** – standard = 30 days **Type A** = 23 days **Type B** = 45 days
Uncorrected Type A or Type B Imposed = provider should provide written notification of intended correction date

Legacy Human Services, Inc.

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

April 6, 2025

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 standard level deficiency cited at the Vance Adult Group Home, Located at 941 Hwy 158 Bypass, Henderson, NC 27536. This is in conjunction with MHL #: 091-118.

You shall find upon return that the deficiencies cited have been addressed globally and the correction has been made prior to the correction date of **May 25, 2025**. 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

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