Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-263	A. BUILDING: _____ B. WING _____	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY LIVING CENTER CENTER	218 ADAMS STREET BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and complaint survey was completed on October 9, 2025. The complaint was substantiated (intake #NC00233381). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. This facility is licensed for 6 and has a current census of 5. The survey sample consisted of audits of 3 current client.	V 000		
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; (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.	V 112	Administrator will ensure all PCP's are signed and dated at the time of completion by all parties. If consumer refuses to sign we will provide documentation of that refusal with the PCP. We will audit all client records every 60 days to prevent any lapses in documentation.	10/21/25

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Sharda L TITLE Administrator (X6) DATE 10/21/2025

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to have a Person Centered Plan with written consent or agreement by the responsible party, or a written statement by the provider stating why such consent could not be obtained affecting 1 of 3 clients (#2). The findings are: Review on 10/8/25 of Client #2's record revealed: -Admission date of 11/10/22. -Diagnoses of Schizophrenia- Chronic Undifferentiated, Schizotypal Personality Disorder, Anxiety Disorder Not Otherwise Specified (NOS), Hypercholesterolemia and Gastroesophageal Reflux Disorder (GERD). -Client #2 was his own guardian. -The last Person Centered Plan signed by Client #2 was dated 6/1/24. -Client #2's Person Centered Plan had no current written consent or agreement by his person. Interview on 10/8/25 with Staff #4 revealed: -She had just started working at the facility this month. -She was not aware that Client #2's Person Centered Plan was incomplete. -She was informed by the Qualified Professional that Client #2's Person Centered Plan had been created; however, he had refused to sign it because he was paranoid about signing	V 112		

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V 112	Continued From page 2 paperwork. Interview on 10/9/25 with the Director revealed: -She confirmed that Client #2 would at times be paranoid about signing paperwork and had refused to sign the Person Centered Plan this year. -She confirmed that the Person Centered Plans for client #2 had no written signed consent or agreement by his person or explanation on why the consent was not obtained.	V 112		
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. (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	V 118		

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V 118	Continued From page 3 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 interview, observation and record review, the facility failed to ensure the MAR was kept current affecting 2 of 3 clients (Client #1 and Client #3). The findings are: Review on 10/8/25 of Client #1's record revealed: -Admission date of 7/17/24. -Diagnoses of Schizoaffective Disorder-Bipolar Type, Anxiety Disorder-Unspecified, Hypothyroidism, Polysubstance Use Disorder, Obesity, Seborrheic Dermatitis, Tinea Cruris, Vitamin D Deficiency, Sleep Apnea, Eosinophilia and Onychomycosis. -Physician order dated 9/30/25 for Ingrezza 80 milligrams (mg)(tardive dyskinesia)- take one capsule daily at bedtime. Observation on 10/8/25 at 11:30 am of Client #1's medications revealed: -Ingrezza 80 mg was available. Review on 10/8/25 of Client #1's MAR for the month of October 2025 revealed: - Ingrezza 80 mg was not listed. Facility staff failed to document administration of medication from 10/1-10/7.	V 118	Staff have been re-trained on proper medication documentation and administration. Staff have also been instructed to review all MAR's following consumer appointments to provide documentation of med changes as they occur. Administrator has also requested MAR's for the Ingrezza that comes from a different pharmacy 10/21/25	

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V 118	Continued From page 4 Review on 10/8/25 of Client #3's record revealed: -Admission date of 6/9/25. -Diagnoses of Schizoaffective Disorder, Bipolar Type; Hypertension; Urinary Incontinence; Chronic Idiopathic Constipation; Dyslipidemia; Vitamin D Deficiency; Nicotine Dependence. -Physician order dated 8/5/25 for Bupropion 100 mg (antidepressant)- Take one tablet twice daily. -Physician order dated 9/30/25 for Bupropion 150 mg- Take two tablets daily. -Physician order dated 9/30/25 indicating Bupropion dosage change from one 100 mg tablet twice daily to two 150 mg tablets once a day. Observation on 10/8/25 at 12:45 pm of Client #3's medications revealed: -Bupropion 100 mg was not available. -Bupropion 150 mg was available. Review on 10/8/25 of Client #3's MAR for the month of October 2025 revealed: -Bupropion 100 mg was marked as administered twice daily 10/1-10/8. -Bupropion 150 mg was marked as administered daily 10/1-10/8. Interview on 10/8/25 with Staff #4 revealed: -She worked mainly as an "as needed" staff. -She had recently started working at this facility full time. -She was responsible for keeping the MAR updated. -Client #1's physician had recently changed his medication. -Client #1's Ingrezza did not come in a "bubble pack" from the pharmacy; instead, it would come in a bottle. -Client #1's Ingrezza had been administered, but since it was not in the MAR, it was not marked as	V 118	to ensure it is on the MAR accurately each month as well as to prevent staff oversight in the future. Administrator will continue the practice of reviewing the MAR on a regular basis as well, starting with twice a month to ensure staff are documenting med changes accurately.	

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V 118	Continued From page 5 administered. -She did not know why Client #'1's Ingrezza had not been listed on his MAR. -She was aware that Client #3's Bupropion dosage had recently changed. -She had not noticed that Bupropion had been listed twice in his MAR and with different dosages. -Client #3's Bupropion came packed in a "bubble pack." -She assumed that all the medications for Client #3 matched his MAR and would mark them as administed each day. -She acknowledges that Client #1's Ingrezza was not listed on the MAR and it had not been marked as administered by facility staff. -She acknowledged that Client #3's Bupropion 100 mg had been marked as administered by staff twice daily the month of October, even though it had been discontinued on 9/30/25 and was in fact not administered. Due to the failure to accurately document medication administration for clients #1 and #3, it could not be determined if they received medication as ordered by their physicians.	V 118		