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
	MHL098-198	A. BUILDING: ______ B. WING ______	11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KYSEEM'S UNITY GROUP HOME LLC #4	**408 TARBORO STREET E WILSON, NC 27893**

(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 11/9/18. The complaint was unsubstantiated (Intake #NC00144730.) Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interview the facility failed to have fire and disaster drills held at least quarterly and repeated on each shift. The findings are: Review on 11/8/18 of facility records from June 2018 thru November 2018 revealed: - No fire drills had been documented from July 2018 through September 2018 on 7 pm - 7 am	V 114	DHSR-Mental Health NOV 2 6 2018 Lic. & Cert. Section	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Nov. 26. 2018 4:35PM No. 1646 P. 2/16

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 114	Continued From page 1 shift, 7 am - 3 pm, or 11 pm - 7 am shifts. - No disaster drills had been documented from July 2018 through September 2018 on 7 pm - 7 am shift, 7 am - 3 pm, or 11 pm - 7 am shifts. Interview on 11/8/18 the Facility Director stated: - The facility opened in June 2018. - The facility operated on a 12 hour rotation on the weekends 7 am - 7 pm and 7 pm - 7 am. - The facility operated a flex schedule on the weekdays between 8 hour shifts and 12 hour shifts: The eight hour shift times were 7 am - 3 pm; 3 pm - 11 pm; and 11 am - 7 am. The 12 hour shift times were 7 am - 7 pm and 7 pm to 7 am.	V 114		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B,	V 366		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KYSEEM'S UNITY GROUP HOME LLC #4	**408 TARBORO STREET E** **WILSON, NC 27893**

(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 366	Continued From page 2 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact	V 366		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KYSEEM'S UNITY GROUP HOME LLC #4	408 TARBORO STREET E WILSON, NC 27893

(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 366	Continued From page 3 within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law.	V 366		

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KYSEEM'S UNITY GROUP HOME LLC #4	**408 TARBORO STREET E WILSON, NC 27893**

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V 366	Continued From page 4 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement a written policy governing their response to level II incidents. The findings are: Review on 11/7/18 of Client #4's record revealed: - 26 year old male admitted on 10/4/18. - Diagnoses included Bipolar Disorder and Post Traumatic Stress Disorder - Person Centered Plan dated 9/9/18 documented Client #4's need for 24 hour supervision. Review on 11/8/18 of facility incident reports revealed - "...[Licensee Name]...Incident Report Statement Form:..." - "...Date of Incident: 10/7/18...Time of Incident: 11:am...Other: Walk OFF..." - "...Staff Name(s) Involved: [Staff # 2]...Individual(s) Involved: [Client #4]...Incident Type:..Other: Runaway..." - "...Statement: on 10/7/18 at approx 11:50 [Client #4] came to me and asked if he could step out back to smoke a cigarette, I told him yes. About 5 minutes later, I decided to go check on him. When I step on the back porch, I noticed it was clear and [Client #4] was not there I walked around the house, to the front porch to check it. When I got around front he wasn't there. I asked the neighbor who was grilling out front about seeing a client and he informed me that, he hadn't seen anyone come past him. I rechecked the house he wasn't here. I then loaded up the clients and circle the blocks. I contact [Facility Director] then the [local police department]. After the [local police department arrived they determined he went over the back fence. They begin combing the surrounding area. I decided to	V 366		

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(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 366	Continued From page 5 help. I located him about 1 1/2 mile away on Ward Blvd. (Boulevard.) When I approach him, he was very aggressive, talkative. He told me to call the law, because he was not going back. I attempted to redirect him but he was not for it. He wanted to he was in a (white out) period. Having conversations with [Client #4] Jason from the movie Friday 13th. [Client #4] voorhees his here. [Local Police Department] arrived evaluated the situation and transported him to the hospital. I went to the hospital until they told me I wan no longer needed. [Staff #2]..." - Signed by Qualified Professional and Facility Director on 10/7/18. Review on 11/7/18 of local police report revealed: - "...Crime Incident(s): Involuntary Commitment... Date: 10/7/18...Time reported: 12:03 Hrs...Location of Incident: 400-BLK Tarboro St. E ...Others Involved:...Reporting Person: [Staff # 2]..." - Narrative of report was not provided to surveyor by the local police department due to their policy and regulations. Interview on 11/8/18 Staff #2 stated: - He was the staff person on duty when the incident on 10/7/18 occurred. - He followed the procedures he knew to do and completed a facility incident report. Interview on 11/8/18 the Facility Director stated: - He did not provide the documentation of the hospital visit from the Involuntary Commitment as requested by surveyor on 11/7/18. - The facility had not followed policy for reporting 10/7/18 incident report as a Level 2 incident. - The facility should have completed the level 2 incident report and their response to the incident involving police response and Client #4's hospital	V 366		

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V 366	Continued From page 6 admission.	V 366		
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 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	V 367		

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KYSEEM'S UNITY GROUP HOME LLC #4	**408 TARBORO STREET E WILSON, NC 27893**

(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 7	V 367		

(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 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

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V 367	Continued From page 8 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 reviews and interviews the facility failed to ensure Level II incident reports were submitted to the Local Management Entity (LME) within 72 hours as required. The findings are: Review on 11/7/18 of the North Carolina Incident Response Improvement System (IRIS) reports for October 2018 revealed no Level II incident reports had been submitted by the facility. Review on 11/8/18 of facility incident reports documented in October 2018 revealed: - One documented incident involving elopement, police, and a hospital admission. Refer to V366 for details.	V 367		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.	V 736		

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(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 736	Continued From page 9 This Rule is not met as evidenced by: Based on observation and interview, the facility was not maintained in a clean, attractive and orderly manner. The findings are: Observation on 11/7/18 at approximately 10:30 am of the facility revealed: - The front living room revealed a sectional couch with 2 cushions missing and 2 table lamps had no light bulbs. The living room ceiling fan had dust on the blades and no working light bulbs. - The hall bathroom revealed a crack across the left corner of countertop for the sink, a broken towel rack, 2 of the bulbs for the vanity were in need of replacement, and the air vent was rusty. The bathroom floor tile had approximately 4 tile squares in need of repair due to cracks and chips. The bathtub had a wash cloth in floor of tub and black mold lined the edge of the tub next to the floor. - Client #1's bedroom revealed 3 light bulbs not working in his ceiling fan, and the blades had a gray film of dust. His dresser had 2 handles missing from the drawers. His air vent was rusty. His bedroom wall adjacent to the doorway had approximately 4 - 5 scuff marks about chair height of the wall. His bedroom carpet was ripped approximately 4 - 4 1/2 inches in an open area of the room. - The hallway airway return vent was gray in color due to the dust in the vent slats. - Client #2's bedroom revealed an approximate softball-sized area of paint peeling on his wall beside his door. Other areas of peeled paint were adjacent to the baseboards in his room. - Client #4's bedroom revealed a broken air vent approximately in the middle of the vent. An area of his carpet in front of his closet had approximately 6 - 8 black spots. The smoke alarm in his room was chirping intermittently.	V 736		

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KYSEEM'S UNITY GROUP HOME LLC #4	408 TARBORO STREET E WILSON, NC 27893

(X4) ID PREFIX TAC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAC	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 736	Continued From page 10 - The back porch revealed a broken bed frame stacked against the side wall. - The pantry/laundry room revealed a missing drawer facing for the shelf organizer. - The kitchen revealed gray duct tape approximately 3 - 4 feet along the baseboard beneath the windows. - The kitchen table had 2 - 3 black ants crawling on the tablecloth which was sticky to touch. Interview on 11/7/18 and 11/8/18 the Facility Director indicated the landlord for the property planned on making repairs such as the flooring and painting.	V 736		

Kyseem's Unity Group Home LLC #4 408 E Tarboro Street, Wilson, NC 27893
MHL # 098-198

PROVIDER'S PLAN OF CORRECTION

V 114 27G .0207 Emergency Plans and Supplies NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES

Indicate what measures will be put in place to *correct* the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).

To *correct* the deficient area of practice, the agency conducted fire drills during all shifts with staff and client participation. A staff meeting is scheduled for 12/1/2018 with all staff and fire drill completion and fire safety will be discuss and reiterated with all staff.

Indicate what measures will be put in place to *prevent* the problem from occurring again.

To prevent this problem from happening again the group home QP and/or CEO will complete a drill schedule for all staff to adhere to. At the end of the month the group QP and/or CEO will ensure the drills were completed by reviewing the drill completion form and if the drill was not complete for the month, the QP and CEO will conduct the drill prior to the start of the new month. This will be completed to ensure all drills are completed minimally on a quarterly basis.

Indicate *who will monitor* the situation to ensure it will not occur again.

Dearl Powell, CEO

Indicate *how often* the monitoring will take place.

This monitoring will take place monthly

V 366 27G .0603 Incident Response Requirements10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS

Indicate what measures will be put in place to *correct* the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).

To ***correct*** the deficient area of practice, the agency QP and CEO a will review the agency's current policy and procedure, and implement the necessary changes to the policy and procedure manual, if needed, to ensure the following take place correctly and by DHSR regulations:

1. Ensure all incidents that may take place are recorded, documented, and reported within the required timeframes, and with DHSR guidelines.
2. Ensure coordination will be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation

Indicate what measures will be put in place to *prevent* the problem from occurring again.

1. A chart indicating the different levels and correct responses to the incident will be posted at each residential sight. All staff will participate in an in-house incident report training. All staff members are to report all identified incidents to QP, and document all incidents immediately. QP will follow the required reporting method per incident and incident level, and report and document the incident within the required timeframes.
2. Upon notification, any disturbances, issues, behavioral issues, incidents, changes, and disruptions that pertain to the clients and the clients' treatment will be communication with the facility operator/CEO, and QP. This communication will be documented in the QP's monthly progress note per client.

Indicate *who will monitor* the situation to ensure it will not occur again.

Dearl Powell, CEO

Indicate *how often* the monitoring will take place.

This monitoring will take place monthly

V 367 27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS

Indicate what measures will be put in place to *correct* the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).

To ***correct*** the deficient area of practice, the agency QP and CEO a will review the agency's current policy and procedure, and implement the necessary changes to the policy and procedure manual, if needed, to ensure the following take place correctly and by DHSR regulations:

3. Ensure all incidents that may take place are recorded, documented, and reported within the required timeframes, and with DHSR guidelines.
4. Ensure coordination will be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation

Indicate what measures will be put in place to *prevent* the problem from occurring again.

1. A chart indicating the different levels and correct responses to the incident will be posted at each residential sight. All staff will participate in an in-house incident report training. All staff members are to report all identified incidents to QP, and document all incidents immediately. QP will follow the required reporting method per incident and incident level, and report and document the incident within the required timeframes. This will be done to ensure Level II incident reports are submitted to the Local Management Entity (LME) within 72 hours as required.
2. Upon notification, any disturbances, issues, behavioral issues, incidents, changes, and disruptions that pertain to the clients and the clients' treatment will be communication with the facility operator/CEO, and QP. This communication will be documented in the QP's monthly progress note per client.

Indicate *who will monitor* the situation to ensure it will not occur again.

Dearl Powell, CEO

Indicate *how often* the monitoring will take place.

This monitoring will take place monthly

V 736 27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS

Indicate what measures will be put in place to correct the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).

To correct the deficient area of practice, any and all issues will be reported to the landlord to be addressed and rectified. Any issues that do not fall under the landlords responsibility will be addressed and rectified by the CEO.

Indicate what measures will be put in place to prevent the problem from occurring again.

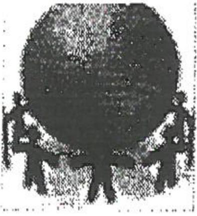
To prevent this problem from happening again, monthly home assessments will be completed and documented. Daily reporting of issues and occurrences will be communicated to the QP and/or agency CEO. Any issues any and all issues will be reported to the landlord to be addressed and rectified. Any issues that do not fall under the landlords responsibility will be addressed and rectified by the CEO

Indicate who will monitor the situation to ensure it will not occur again.

The QP and/or agency director.

Indicate how often the monitoring will take place.

This monitoring will take place monthly.



Kyseem's Unity Adult Group Home, LLC

"A lighter way to a brighter future"

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