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 _____	R 08/15/2019

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 A complaint and follow up survey was completed on August 15, 2019. The complaints were unsubstantiated (Intakes #NC00154385 and #NC00154543). 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 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		

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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 develop and implement strategies based on assessment affecting 3 of 4 audited clients (#1, #2, and #3). The findings are: Review on 8/6/19 of client #1's record revealed: - 26 year old male admitted 10/4/18. - Diagnoses included Schizoaffective Disorder, bipolar type, Intermittent Explosive Disorder, Generalized Anxiety Disorder, Borderline Intellectual Functioning, insomnia, obesity, and gastroesophageal reflux disease. - "Admission Assessment/Screening" dated 10/4/18 included documentation of "frequent" elopements and stealing. - Person Centered Profile dated 4/1/19 Action Plan included short range goals to manage anger, comply with rules, and to learn and use effective communication skills to properly cope with feelings related to misbehaviors and responding appropriately to requests from authority figures. - No training strategies to address the short range goals. - No goal or training strategies to address frequent elopement or stealing. Review on 8/6/19 of client #2's record revealed: - 27 year old male admitted 5/15/18. - Diagnoses included Schizoaffective Disorder, bipolar type, Mild Intellectual/Developmental Disability, seizure disorder, and nocturnal enuresis. - Person Centered Profile dated 5/29/19 Action Plan included short range goals to reduce cigarette smoking, manage anger without	V 112		

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V 112	Continued From page 2 aggressive behaviors, decrease incidents of spitting in others' faces, decreasing incidents of night time bedwetting, money management, enhancing safety skills and increasing independent living skills. - No training strategies to address the short range goals. - No goal or training strategies relative to medication management. Review on 8/6/19 of client #3's record revealed: - 38 year old female admitted 3/17/19. - Diagnoses included Moderate Intellectual/Developmental Disability, Generalized Anxiety Disorder, bipolar with psychotic features, chronic urinary tract infections, asthma, and gastroesophageal reflux disease. - Person Centered Profile dated 5/24/19 Action Plan included short range goals to properly clean herself after each visit to the bathroom, bathing daily, decreasing incidents on non-compliance and confrontation with peers, taking medications daily, and decreasing incidents of elopement. - No training strategies to address the short range goals. During interview on 8/7/19 the Chief Executive Officer stated staff provided clients with verbal prompts and praise when goal training. Staff kept grid sheets to document goal training.	V 112		
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	V 366		

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V 366	Continued From page 3 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, 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;	V 366		

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V 366	Continued From page 4 (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 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	V 366		

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V 366	Continued From page 5 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. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to document their response to level I and level II incidents. The findings are: Review on 8/6/19 of deceased client #4's (DC#4) record revealed: - 49 year old male admitted 6/20/18. - Diagnoses included Schizoaffective Disorder, Mood Disorder, unspecified, depression, mild Intellectual/Developmental Disability, hypercholesterolemia, and dementia. Review on 8/6/19 of facility incident reports from 7/1/19 - 8/5/19 revealed: - Level II North Carolina Incident Response Improvement (IRIS) report #a8937537od included "Date of Incident 7/30/2019" with attached typed timeline that included: "On 7/30/19 - PSR [psychosocial rehabilitation program] called [Chief Executive Officer, CEO] to informed him that [DC#4] knees maybe infected and possibly needs medical attention . . . [DC#4] was evaluated at [local medical hospital], upon that evaluation	V 366		

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V 366	Continued From page 6 blood work was done . . . [CEO] was told by ED [Emergency Department] MD [Medical Doctor] that there was possible bleeding on the first scan and [DC#4] may possible be transferred to [Regional Medical Center], however, they are not sure due to excessive movement . . . A second scan was later done. [CEO] was told a total of 3.5 mg [milligrams] of Ativan was given to [DC#4] in his stay at [local medical hospital]. Second scan came back negative, however [DC#4] was not back at baseline, so [CEO] did not feel safe bringing [DC#4] back to the group home. MD at hospital believed [DC#4] needed time to allow the Ativan to get out of his system." - "8/1/19-approx [approximately] 11 pm [local police department] office brought [DC#4] to Group home via ambulance but Staff was instructed not to take [DC#4] from [police department] because [CEO] did not feel comfortable accepting [DC#4], who was being escorted via ambulance and still not back to baseline. . . " - "Incident Report Statement Form" dated 7/29/19 included "Incident type: . . . bruise . . . "with hand written statement "On 7/29/19 @[at] around 3:45pm I noticed [DC#4] knees was red and he had bruises on his knees as well. I asked what happen to [DC#4] knees and [sister facility client] and [client #2] told me he falled down at [PSR] and hurt his knees and arm and [PSR Qualified Professional] had to help him up. So I ask [DC#4] was he hurting and [DC#4] said No. I press his knee to see if he would make any frown to see if he was in pain and [DC#4] was ok at the time." - Radiology reports from the local medical hospital for "MRI [magnetic resonance imaging] Brain Diffusion" dated 7/30/19 and "CT [computed tomography] Head WO [without] Contrast" included "Adm Dx [Admitting Diagnosis]	V 366		

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V 366	Continued From page 7 Fall/Altered Mental Status"; both reports included "Impression: No acute intracranial abnormalities." - No documentation the Licensee took measures to determine the cause of the incident or develop and implement corrective measures to prevent similar incidents in the future. During interviews on 8/6/19 clients #1, #2, and #3 stated DC#4 leaned back when he walked but they never saw him fall at the facility. During interview on 8/8/19 staff #1 stated she had no knowledge of DC#4 falling at the facility prior to 8/4/19 when she found him unresponsive on his bedroom floor. During interview on 8/8/19 staff #2 stated: - He normally worked 7:00 am - 7:00 pm. - DC#4 had fallen twice since March 2019 at the group home while he was on duty and he did a written incident report for both falls. - DC#4 "landed on his butt both times" and sustained no injuries. - "I asked DC#4 if he was okay and he said he was"; both falls occurred inside the facility. - "There was no incident." During interviews on 8/6/19 and 8/7/19 the Chief Executive Officer stated: - "[PSR] staff called and asked if I had seen his knees." - He instructed staff #2 to pick DC#4 up from the PSR and take him to the local hospital emergency room on 7/30/19. - "2 consumers told staff [DC#4] fell at the school on Monday." This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 366		

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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 (2) the provider obtains information required on the incident form that was previously unavailable.	V 367		

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V 367	Continued From page 9 (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 been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs	V 367		

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V 367	Continued From page 10 (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 submit Level II incident reports within 72 hours as required. The findings are: Review on 8/6/19 and 8/7/19 of the North Carolina Incident Response Improvement System (IRIS) reports between 7/1/19 and 8/5/19 revealed no Level II incident reports submitted by the facility. Review on 8/6/19 of deceased client #4's (DC#4) record revealed: - 49 year old male admitted 6/20/18. - Diagnoses included Schizoaffective Disorder, Mood Disorder, unspecified, depression, mild Intellectual/Developmental Disability, hypercholesterolemia, and dementia. Review on 8/6/19 of facility incident reports from 7/1/19 - 8/5/19 revealed: - Level II IRIS report #3b26f86d06 included "Date of Incident 8/4/2019" with attached typed timeline that included "On 8/4/2019-Approx. 0630 staff assisted [DC#4] with bath Approx. 0700-staff told [DC#4] to go back in his room watch TV, while staff gets meds [medications] and breakfast ready Approx. 0713-Staff heard a loud thump in [DC#4]'s room, staff went in [DC#4] room and asked [DC#4] why are you on the floor what's going on? Staff went to assess [DC#4] and noted; his eyes was open but he was not responding. Staff immediately checked for a pulse and did not feel a pulse. Approx. 0714- EMS [Emergency	V 367		

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V 367	Continued From page 11 Medical Services] was called, and CPR [cardiopulmonary resuscitation] was started immediately with [DC#4] lying on the floor. . . . EMS arrived in about 5 mins [minutes], . . . Once EMS arrived, they resumed CPR and transported [DC#4] to hospital. . . . " - "Statement Form" included "Date of Incident: 8/4/19" included a handwritten statement signed by staff #1 and dated 8/4/19 with the same information include in the typed timeline dated 8/4/19. During interviews on 8/6/19 and 8/7/19 the Chief Executive Officer stated: - DC#4 passed away 8/5/19. - Detectives from the local Police Department had interviewed facility staff regarding DC#4 and the events prior to his death. - Level II incidents were entered into IRIS as required and he had a confirmation number showing completion of the incident report submission. He completed all required fields when entering information into the IRIS system. Refer to v366 for additional details. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	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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V 736	Continued From page 12 This Rule is not met as evidenced by: Based on observation and interview the facility was not maintained in a safe, clean, and orderly manner. The findings are: Observations of the facility on 8/6/19 at approximately 10:20 am revealed: - Particulate matter and food crumbs on the kitchen floor and floors throughout the facility. - Greasy splatters on the control pane of the stove. - A coffee can and coffee cup containing what appeared to be used cooking oil on the counter beside the stove and a pot of cooking oil on the stove. - The finish on the kitchen cabinets over the stove had dried greasy splatters. - The vanity in the hall bathroom was cracked at the front of the sink. - The toilet paper holder in the hall bathroom was broken and non-functional. - Client #1's mattress had numerous dark brown stains. - The smoke detector in client #1's bedroom chirped at regular intervals throughout the survey process. - An unfinished repair, approximately 8 inches by 8 inches, to the wall by client #1's bed. - The paint on client #1's bedroom walls was scuffed. - The finish on client #2's dresser was worn and scratched. - No bedside table in client #2's bedroom. - Client #3's bedroom closet was missing a handle. - The ceiling in client #3's bedroom had a dark dusty pattern. - The paint on client #3's bedroom walls was	V 736		

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V 736	Continued From page 13	V 736		

scuffed.
- A smoke detector in deceased client #4's (DC #4) bedroom chirped at regular intervals throughout the survey process.
- A brown fabric sofa in the living room was missing 1 of 3 back cushions.
- A brown leather sectional sofa with 2 missing cushions.
- Several lightbulbs throughout the facility were not working.

Observation on 8/6/19 at approximately 11:30 am the Licensee turned on the stove with a pot of cooking oil on the burner "to get lunch started"; the oil overheated which activated smoke detectors throughout the facility.

Observation on 8/7/19 at approximately 12:30 pm of DC #4's bedroom revealed a dry, round, reddish brown spot, approximately 4 inches in diameter, and several pieces of clear plastic with metal snaps that appeared consistent with electrocardiograph electrodes on the floor.

During interview on 8/6/19 client #1 stated he did not know how long the smoke detectors had been chirping.

During interview on 8/6/19 client #2 stated the smoke detectors had been chirping for "a while, maybe a week. [Chief Executive Officer] tried to fix it but he didn't have batteries."

During interview on 8/6/19 the Chief Executive Officer (CEO) stated all 3 clients had toileting accidents the previous night. He would get new light bulbs to replace those that were not working. The smoke detectors had only been chirping for one day; he would replace the batteries in the smoke detectors. The other smoke detectors in

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 _____	R 08/15/2019

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 736	Continued From page 14 the facility were working appropriately. During interview on 8/7/19 the CEO stated the reddish brown spot on DC #4's bedroom floor looked like a blood stain; "I didn't know that was there. I need to get them to sanitize this room." Emergency Medical Services personnel left trash on DC #4's bedroom floor on 8/4/19. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		