STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

(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 survey was completed on October 13, 2021. 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 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.	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

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V 109	Continued From page 1 (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. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that 1 of 1 Licensee (L)/Qualified Professional (QP) demonstrated the knowledge, skills and abilities required by the population served. The findings are: Review on 10/08/21 of the L/QP record revealed: -Hire date of 03/01/16. Refer to V112 regarding clients' treatment plans. -Client #2's Individual Support Plan revealed he should have a one-on-one staff and 2 staff in the facility to assist with his behaviors and outbursts. -Client #3 was allowed to be unsupervised in the neighborhood for walks and assisting neighbors with yard work and was not documented in the treatment plan for unsupervised time. -The L/QP acknowledged she had not provided the one-on-one for client #2 since March 2020 and she was responsible for implementing, developing and making revisions for client #3's treatment plan. Refer to V118 regarding medication errors for client #1 and client #2. -Client #1's September 2021 Medication Administration Record (MAR) had blanks and it was unable to be determined if client #1 received	V 109		

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	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

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UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

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V 109	Continued From page 2	V 109		

the medication on those dates.
-Client #1 was not administered two medications in July 2021 due to the facility running out of the medication.
-Client #2's October 2021 MAR had no initials to indicate a medication had been administered in the morning from 10/01/21-10/11/21.
-Client #2's Clonidine 0.1mg was transcribed on the October 2021 MAR and had initials indicating the medication had been administered from 10/01/21-10/13/21 and no physician order was provided.
-The L/QP was unaware of the medication issues in the home.

Refer to V123 regarding not contacting the pharmacist or physician due to medication errors.
-Client #1's July 2021 MAR revealed client #1 was not given two medications because the facility ran out the medications.
-The facility did not contact the pharmacist or physician to determine if client #1 would have had any adverse reaction for not receiving the medication.
-The L/QP was unaware of the medication issues in the home.

Refer to V290 for not providing adequate staff in the facility to meet the needs of the clients.
-Approximately 11 Level 1 incident reports were documented and the behaviors including biting, hitting, threatening and property damage.
-Only one staff was working in the home on each shift and was unable to respond to individualized client needs.
-The L/QP had reviewed the incident reports and was aware of the behaviors in the home.

Refer to V291 for not coordinating with outside professionals.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

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V 109	Continued From page 3 -Client #2 attending a dental appointment on 02/16/21 for dental cleaning and an extraction of a tooth. -A referral was made from the dentist for an oral surgeon for root removal of the extracted tooth. -Client #2 did not see an oral surgeon and the L/QP did not follow up with the guardian for consent for client #2 to be sedated and have the roots removed from the extracted tooth. Refer to V366 for not completing Level I incident reports for missed medications. -Client #1 missed medications due to the facility running out of the medications. -The L/QP did not know Level I incident reports needed to be completed for medication errors. Refer to V367 for not completing Level II incident reports. -Client #1 was sent to the emergency room on 06/18/21 due to a laceration above his right eye from an altercation with another client. -Client #1 and client #2 were in an altercation on 10/07/21 which resulted in severe bite wounds, bruising and cuts on each client and the facility only completed a Level I incident. -The L/QP did not know each of those incidents required a Level II incident. During interview on 10/13/21 the L/QP revealed: -She was unaware of of the medication issues and the incident that occurred on 10/07/21. -She would ensure all the staff are properly trained and would ensure all the staff are inserviced on the behaviors of the clients. -She would ensure the adequate staffing would be applied in the facility to meet the needs of the clients.	V 109		

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	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

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V 109	Continued From page 4 This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation 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; (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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	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

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V 112	Continued From page 5 This Rule is not met as evidenced by: Based on observation, record reviews and interviews the facility failed to develop and implement goals and strategies to address needs of 2 of 3 clients (#2 and #3). The findings are: Finding #1 Review on 10/13/21 of client #2's record revealed: -25 year old male. -Admission date of 12/03/10. -Diagnoses of Oppositional Defiant Disorder, Severe Mental Retardation and Encephalopathy. Review on 10/13/21 of client #2's Individual Support Plan dated 01/01/21 revealed: "-Supports I need:...[Client #2] would benefit from having an one-on-one worker with him in the home and in the community, due to his recent behaviors/outburst. -My behavioral Health Needs:...[Client #2] will yell, cuss, make threats and attempt to play out his threats...[Client #2] will bite, tries to cut others with a butter knife or plastic knife, kicks, and scratches. This has occurred about 5 times in the last 12 months. He was IVC (involuntary committed) at [Local Hospital] and released back to the home in August for attacking a staff member while she was driving, biting one of his housemates and pulling a knife on the staff member...[Client #2] punches holes in walls and breaks up TV's, radios and anything he can get his hands on when he is upset...[Client #2] would benefit from having an one-on-one worker with him in the home and in the community. [Client #2] now has two staff persons with him at all times due to his recent behaviors." Observation on 10/11/21 at approximately	V 112		

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	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

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V 112	Continued From page 6 9:30am revealed: -Client #1, Client #2 and Client #3 were in the home. -Staff #1 was the only staff in the facility. During interview on 10/11/21 client #1 revealed -Only one staff worked each shift. -He did not know if client #2 had a one-on-one worker. -He did not have a one-on-one worker. -He was tired of being hit by the other clients. -He and client #2 got in fights a lot. During interview on 10/11/21 client #2 stated: -He did not have a one-on-one worker. -Only one staff worked each shift. -He and client #1 got in fights a lot. During interview on 10/11/21 staff #1 revealed: -She had worked at the facility since January 2021. -She worked first shift during the week from 8:00am-4:00pm. -She worked by herself in the facility. -None of the clients in the facility had one-on-one workers. During interview on 10/13/21 the Group Home Manager revealed: -He had been the Group Home Manager for 2 years. -Each shift had one staff and the staff would call him if they need him because he took care of two other sister facilities. -He was not able to be everywhere and if staff need help they know to call the office. -Client #2 did not have a one-on-one worker. During interview on 10/13/21 the Licensee(L)/Qualified Professional(QP) revealed:	V 112		

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	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

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V 112	Continued From page 7 -"Client #2 did not have a one-on-one worker with him since March 2020 when COVID started." -"The one-on-one he had quit due to being exposed to COVID." -The facility had three shifts and each shift had one staff. Finding #2 Review on 10/13/21 of client #3's record revealed: -19 year old male. -Admission date of 02/19/20. -Diagnoses of Mild Intellectual Developmental Disability, Attention Deficit Disorder, Depressive Disorder, Conduct Disorder. Review on 10/13/21 of client #3's Person-Centered Profile dated 02/12/21 revealed: "-Long Range Outcome: [Client #3] will learn and implement anger management skills that reduce irritability, anger and aggressive behaviors which improving his attitudes. -Where am I now in the process of achieving this outcome:...[Client #3's] behavior has deteriorated over the last 30 days to the point where he leaves the house without permission and is aware that he can remain gone for two hours without the police being called. He will steal from his peers and from his employers. When confronted about stealing, [Client #3] will deny it until he becomes afraid and confesses...[Client #3] wants to do manual labor. He trimmed the hedges for an elderly neighbor. [Client #3] should obtain permission before taking odd jobs. The owner explained [Client #3's] status in the area and that he needed permission to secure tiny jobs. [Client #3] will sneak out of the house and ask for cigarettes from neighbors...[Client #3] will steal stuff without authorization (cash, electronics, jewels)."	V 112		

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	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

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UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

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V 112	Continued From page 8 -No documentation in the Person-Centered Profile for client #3 to have unsupervised time in the home or in the community. During interview on 10/11/21 client #3 revealed: -He had lived at the facility since last year. -He did not like living at the facility. -He was allowed to walk in the neighborhood without staff. -He would walk to get out of the house or to calm down if he was angry. -He had helped a lady in the neighborhood with her yard to make extra money. During interview on 10/11/21 staff #1 revealed: -Client #3 will walk around the house or down the street. -Client #3 helps a lady down the street. -Client #3 would always tell her where he was going. During interview on 10/13/21 the Group Home Manager revealed: -Client #3 helps a elderly lady down the street to clean her yard. -Client #3 will walk down the road or go in the yard to get a break. -Client #3 is always in eye sight of staff. During interview on 10/13/21 the Licensee/QP revealed: -In the past client #3 had helped a lady in the neighborhood with her yard. -She thought she had added the unsupervised time to his treatment plan. -She would ensure the information was added to the treatment plan. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1	V 112		

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	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

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V 112	Continued From page 9 rule violation and must be corrected within 23 days.	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 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.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

(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 118	Continued From page 10	V 118		

This Rule is not met as evidenced by:
Based on record reviews, interviews and observations, the facility failed to administer medications on the written order of a physician and failed to keep the MARs current affecting 2 of 3 clients (#1, #2). The findings are:

Finding #1
Review on 10/13/21 of client #2's record revealed:
-25 year old male.
-Admission date of 12/03/10.
-Diagnoses of Oppositional Defiant Disorder, Severe Mental Retardation and Encephalopathy.

Review on 10/11/21 of client #2's Physician orders revealed:
06/15/21
-Montelukast SOD (Sodium) 10mg (milligram) (used to prevent asthma attacks in adults and children)Take 1 tablet by mouth daily.
-Topiramate 25mg (used to treat certain types of seizures in adults and children) Take 2 tablets by mouth twice daily.
-No Physician order for Clonidine HCL 0.1mg Take 1 tablet by mouth twice daily as needed for irritability and agitation as documented on the August and October 2021 MAR.

Review on 10/11/21 of client #2's July-October 2021 MAR revealed:
-Topiramate 25mg was transcribed on the MAR and 7pm was handwritten.
-No initials at 7am to indicate the Topiramate 25mg had been administered.
-Clonidine HCL 0.1mg was transcribed on the August 2021 MAR and did not have any initials to

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	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

(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 118	Continued From page 11 indicate the medication had been administered. -Clonidine HCL 0.1mg was not transcribed on the September 2021 MAR. -Clonidine HCL 0.1mg was transcribed on the October 2021 MAR and had initials at 7am and 7pm from October 1-13 to indicate the medication had been administered. -No documentation on the back of the MAR explaining why the PRN medication was administered daily. Observation on 10/11/21 of client #2's medication box at approximately 10:05am revealed: -No Montelukast SOD (sodium) 10mg was present. -Clonidine HCL 0.1mg was not in the medication box but was on the top shelf of the medication closet and was dated 11/4/20 and 21 pills of the bubble pack were not present indicating the medication had been administered. -Topiramate 25mg was dispensed by the pharmacy on 08/21/21. -The medication box had two bubble packs of Topiramate 25mg labeled 7am and 7pm and the bubble packs had medication removed from the bubbles indicating the medication had been removed. During interview on 10/11/21 client #2 revealed: -He did not know what medication he took. -He received his medication every day. During interview on 10/13/21 staff #3 revealed: -He had worked at the facility approximately 2 months. -He had been trained in medication administration training. -He worked 3rd shift and he administered the morning medications to the clients. -He only administered medication that was in	V 118		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

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V 118	Continued From page 12 each client's medication box. -"If Topamax was given at 7am then I gave it." Finding #2 Review on 10/13/21 of client #1's record revealed: -24 year old male. -Admission date of 03/03/16. -Diagnoses of Depressive Disorder, Cerebral Palsy and Post Traumatic Stress Disorder. Review on 10/13/21 of client #1's Physician orders revealed: 01/25/21 -Omeprazole DR 20mg (used to treat symptoms of gastroesophageal reflux disease) Take 1 capsule by mouth daily. 06/16/21 -Primidone 50mg (used to control seizures) Take 1 tablet by mouth every day at seven in the morning. 06/25/21 -Risperidone 0.25mg (used to treat schizophrenia in adults and children) Take 1 tablet by mouth every day at seven in the evening for 30 days. -Sertraline HCL 25mg (used to treat major depressive disorder, obsessive-compulsive disorder, panic disorder, social anxiety disorder, and post-traumatic stress disorder) Take 1 tablet by mouth every day at seven in the evening for 30 days. Review on 10/11/21 of client #1's September 2021 MAR revealed the following blanks: -Omeprazole Dr 20mg-09/23/21 -Primidone 50mg-09/23/21 -Risperidone 0.25mg-09/23/21 -Sertraline HCL 25mg-09/23/21 Review on 10/13/21 of client #1's July 2021 MAR	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

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V 118	Continued From page 13 revealed: -Omeprazole Dr 20mg had an X instead of initials from 07/22/21-07/26/21. -Risperidone 0.25mg had initials with a circle around on 07/19/21. -The back of the MAR was transcribed Risperidone and Omeprazole were not given on those dates because staff were waiting on refills. During interview on 10/11/21 client #1 revealed: -He did not know the names of his medication. -He received his medication everyday. During interview on 10/13/21 the Group Home Manager revealed: -He had been the Group Home Manager for 2 years. -He was responsible for three homes. -Client #2 was not supposed to be on the Clonidine. -Client #2 "went to the hospital several months back and the hospital prescribed the Clonidine and his doctor did not want him to be on the Clonidine." -The office staff contacted the pharmacy and they did not have an order for the Clonidine and did not give a reason why they transcribed the Clonidine on the MAR. -He would also contact the pharmacy to ensure client #2's Topiramate had 7am and 7pm on the MAR. During interview on 10/13/21 the Licensee (L)/Qualified Professional (QP) revealed: -The staff were taking medication administration refresher training on 10/13/21. -She would make sure the staff were trained on medication errors and not leaving the MAR without initials.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

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V 118	Continued From page 14 This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 118		
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted. . This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure medication errors were reported immediately to a physician or pharmacist affecting 1 of 3 clients (#2). The findings are: Review on 10/13/21 of client #1's record revealed: -24 year old male. -Admission date of 03/03/16. -Diagnoses of Depressive Disorder, Cerebral Palsy and Post Traumatic Stress Disorder. Review on 10/13/21 of client #1's July 2021 MAR revealed: -Omeprazole Dr 20mg had an X instead of initials	V 123		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

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V 123	Continued From page 15 from 07/22/21-07/26/21. -Risperidone 0.25mg had initials with a circle around on 07/19/21. -The back of the MAR was transcribed Risperidone and Omeprazole were not given on those dates because staff were waiting on refills. Review on 10/13/21 of facility records revealed no documentation a physician or pharmacist was notified of medication errors with client #1's Risperidone and Omeprazole on 07/19/21 and 07/22/21-07/26/21. During interview on 10/13/21 the Group Home Manager revealed: -The staff were supposed to contact him when the medication gets to 10 pills left in the bubble pack. -The staff do not always tell him when the medication was getting low.. -If the staff do not tell him the medication is low or has run out he did not know to contact the pharmacy or the doctor if a refill was needed. During interview on 10/13/21 the Licensee/Qualified Professional revealed: -She had new staff in the facility and the old staff making the errors was no longer working at the facility. -She would ensure all staff were re-trained in medication administration and also re-trained when to contact the office for medication refills. -She would update the Level I incident report to include medication errors to include the pharmacy or doctor was contacted if the client missed a medication. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation and must be corrected within 23	V 123		

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	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

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V 123	Continued From page 16 days.	V 123		
V 289	27G .5601 Supervised Living - Scope 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E" designation means a facility which serves adults whose primary diagnosis is	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

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V 289	Continued From page 17 substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7)(A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1)(i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e)(1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL). This Rule is not met as evidenced by: Based on record reviews, observations, and interviews, the facility failed to ensure care, habilitation, and supervision designed to meet the needs of the individuals affecting 3 of 3 clients (#1-#3). The findings are: A. Cross reference 10A NCAC 27G .0203 Competencies of Qualified Professional and Associate Professionals (tag v109). Based on record reviews and interviews, the facility failed to ensure that 1 of 1 Licensee (L)/Qualified	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

(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 289	Continued From page 18 Professional (QP) demonstrated the knowledge, skills and abilities required by the population served. B. Cross reference 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (tag v112). Based on observation, record reviews and interviews the facility failed to develop and implement goals and strategies to address needs of 2 of 3 clients (#2 and #3). C. Cross reference 10A NCAC 27G .0209 Medication Requirements (tag v118). Based on record reviews, interviews and observations, the facility failed to administer medications on the written order of a physician and failed to keep the MARs current affecting 2 of 3 clients (#1, #2). D. Cross reference 10A NCAC 27G .0209 Medication Requirements (tag v123). Based on record reviews and interviews, the facility failed to ensure medication errors were reported immediately to a physician or pharmacist affecting 1 of 3 clients (#2). E. Cross reference 10A NCAC 27G .5602 Staff (tag v290). Based on record reviews, observations, and interviews the facility failed to ensure staff-client ratios above the minimum number to enable staff to respond to individualized client needs affecting 3 of 3 clients (#1, #2, #3). F. Cross Reference 10A NCAC 27G .5603 Operations (tag v291). Based on record reviews and interviews the facility failed to maintain coordination between the facility operator and the professionals who are responsible for the client's treatment affecting 1 of 3 clients (#2).	V 289		

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	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

(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 289	Continued From page 19 G. Cross Reference 10A NCAC 27G .0603 Incident Response Requirements for Category A and B Providers (tag v366). Based on record reviews and interviews, the facility failed to implement written policies for response to level I incidents of medications errors. H. Cross Reference 10A NCAC 27G .0604 Incident Reporting Requirements for Category A and B Providers (tag v367). Based on record reviews and interview, the facility failed to report a critical incident to the home and host Local Management Entity (LME) within 72 hours as required. Review on 10/13/21 of the Plan of Protection dated 10/13/21 and completed by the Qualified Professional/Licensee revealed: "-What immediate action will the facility take to ensure the safety of the consumers in your care? Unity Home Care will adhere to the ISP (Individual Support Plan) and add unsupervised time to cover when the clients go for a neighborhood walk; the Director will use the IRIS system to continue to input incident reports. The staff is currently in MARs (Medication Administration Training) to become more knowledgeable about medication errors and needs. Unity Home Care staff has contacted the Pharmacist to discuss rectifying the MARs. The Director has scheduled medication error training for level 1 incidents on the incident report. The Director will follow up on any referral to the legal guardian until the referral is followed through. Unity Home Care will retrain the staff on supervision. The Director will provide adequate staffing for the consumer in the home and oversee the home. -Describe your plans to make sure the above happens.	V 289		

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
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

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V 289	Continued From page 20 The Director will monitor the ISP and work with the Case Manager to make appropriate adjustments and improvements. The Director will contact the Pharmacist on the medication issues and ensure that an incident report is generated and entered into the IRIS system within 24 hours of the incident. The Director will monitor the MARs for any necessary incident reports. Staff training in all areas and the Director will oversee the staff and clients for their health and safety." Clients #1-#3 had diagnoses which included Mild to Severe Intellectual Developmental Disabilities, Oppositional Defiant Disorder and Conduct Disorders. Behaviors exhibited by the individuals included biting, punching, property damage, aggressive behaviors towards staff and threatening harm to others. The individual support plans and person-centered plans did not address the unsupervised time in the community for client #3 and the one-on-one staff was not implemented for client #2. Client #1's and client #2's medication administration record had numerous medication errors including client #1 not getting his Omeprazole and Risperidone medications as prescribed due to the facility running out of medications and the errors on the medication administration record. The facility did not coordinate services for client #2 to receive appropriate dental care to have tooth root removed after an attempted extraction of a tooth. The facility did not have enough staff on each shift to address the behaviors of repeated biting, fighting each other and causing harm which resulted in a laceration of the right eyebrow to client #1 or the required one-on-one staff for client #2 as indicated in the Individual Support Plan. Level I and level II incident reports were not completed or reported for medication errors and documentation of injuries during the altercations	V 289		

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V 289	Continued From page 21 with the clients. The Licensee/Qualified professional was relying on the Group Home Manager to oversee the daily functions of the group home also while he was in charge of and responsible for the day to day function of two other facilities. The failure to implement 1:1 supervision for client #2, failing to administer medication as ordered and documenting the incident reports as required constitutes a Type A 1 rule violation for serious harm and neglect and must be corrected within 23 days. An administrative penalty of $2000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 289		
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 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	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

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V 290	Continued From page 22 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 reviews, observations, and interviews the facility failed to ensure staff-client ratios above the minimum number to enable staff to respond to individualized client needs affecting 3 of 3 clients (#1, #2, #3). The findings are: Review on 10/13/21 of client #1's record revealed: -24 year old male. -Admission date of 03/03/16. -Diagnoses of Depressive Disorder, Cerebral	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

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V 290	Continued From page 23 Palsy and Post Traumatic Stress Disorder. Review on 10/13/21 of client #2's record revealed: -25 year old male. -Admission date of 12/03/10. -Diagnoses of Oppositional Defiant Disorder, Severe Mental Retardation and Encephalopathy. Review on 10/13/21 of client #3's record revealed: -19 year old male. -Admission date of 02/19/20. -Diagnoses of Mild Intellectual Developmental Disability, Attention Deficit Disorder, Depressive Disorder, and Conduct Disorder. Review on 10/13/21 of client #2's Individual Support Plan dated 01/01/21 revealed: "-Supports I need:...[Client #2] would benefit from having an one-on-one worker with him in the home and in the community, due to his recent behaviors/outburst. -My behavioral Health Needs:...[Client #2] will yell, cuss, make threats and attempt to play out his threats...[Client #2] will bite, tries to cut others with a butter knife or plastic knife, kicks, and scratches. This has occurred about 5 times in the last 12 months. He was IVC (involuntary committed) at [Local Hospital] and released back to the home in August for attacking a staff member while she was driving, biting one of his housemates and pulling a knife on the staff member...[Client #2] punches holes in walls and breaks up TV's, radios and anything he can get his hands on when he is upset...[Client #2] would benefit from having an one-on-one worker with him in the home and in the community. [Client #2] now has two staff persons with him at all times due to his recent behaviors."	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

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V 290	Continued From page 24 Review on 10/13/21 of the facility's Level 1 incident reports revealed: "-1/2/21 at 5:30pm-[Client #1] bit [Client #3] after [Client #3] grabbed him so he could put him in a choke hold. [Client #3] slammed [Client #1] to the ground. [Client #1] continued to yell and use swear words toward staff and clients. [Client #1] then threw a cup towards staff because she was asking him to stop throwing the paper towels at [Client #2]. Staff let [Client #3] go into the living room while [Client #1] continued to yell. Staff allowed [Client #1] to go outside after he stopped yelling. When [Client #1] go outside he began yelling again. Staff asked him not to yell but he continued to anyway. Staff decided to call staff member [Former Staff (FS) #4] to see if he could asist with calming [Client #1]. After [Client #1] spoke with [FS #4], he stopped yelling. -1/27/21 at 5:30pm-[Client #2] began to pick on [Client #1] while [Client #1] was sitting in the living room. [Client #2] hit [Client #1] in the head with a container lid. [Client #1] yelled at [Client #2] to stop. [Client #2] then started to fan [Client #1] causing [Client #1] to yell at him again. Staff saw that [Client #2] was getting angry and tried to distract him with watching television. [Client #2] decided he did not want to watch television so he punched [Client #1] in the face several times. [Client #2] also pushed [Client #1] from a chair and kicked him. Staff then grabbed [Client #2] by his right arm and guided him to his room so he would no longer attack [Client #1]. -2/1/21 at 10:15am-Clients was sitting in the smaller sofa together when an argument broke out. [Client #2] hit [Client #1]. Then he bites him. Then [Client #1] chokes [Client #2] as I'm trying to break them lose they still continue to fight. Then [Client #3] interferes to try and break it up then [Client #1] hits [Client #3] and [Client #3] returns	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

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V 290	Continued From page 25	V 290		

the blow. Fight was over and [Client #1] continue to yell at staff and clients.
-2/1/21 at 2:15pm-[Client #2] and [Client #3] was arguing when [Client #2] went into the drawer of the kitchen and grabbed a can opener and threatened [Client #3] with it. Then [Client #3] pushed [Client #2] against the cabinet and let go.
-2/3/21 at 1:30pm-While getting ready to leave the doctor's office [Client #1] was being very disrespectful to all clients and staff. He got mad when staff asked him why did he have his walker and took his frustrations out on everyone. He then pushed his walker away from him as it almost rolled down the parking lot. When staff asked him to get it and put it in the back of the van, he then yelled and said he wasn't doing it or getting in. When staff told him to get in the van he yells no as he slammed the door on staff's leg. [Client #2] got out and tried to demand him to get in the van they argue as staff told them both to get in. They got in as they argued and begin to fight in the back seat of the van. [Client #3] then tries to break up the fight from the front seat of the van. [Client #1] pinches [Client #3] on the side that's what made [Client #3] start punching him in the head causing him to have a busted lip. I made them all stop. They stop when I asked. We went straight to the office from there. [Client #1] continues to talk disrespectful to me calling me out my name as he spit blood on the floor of the van after I gave him a wipe to clean his mouth. Then we pulled into the office parking lot and all the fussing stopped.
-2/9/21 at 11:00am-[Client #1] and [Client #2] started fussing then it became physical before it got that far I prompted them to stop several times but they never listened. They continued to fight and I tried to break it up but it didn't work. They finally stop for a moment I tried to make [Client #1] go in his room. He told me no and hit me on

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	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

(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 290	Continued From page 26	V 290		

my leg and pushed my chair back. He continued to argue that's when [Client #3] got up and begin yelling at him telling him to stop. They begin to fight. Then I still commanding him to go in his room but he kept going against me. That's when he hit me in my leg again. [Client #2] grab the basket and tried to hit him I took it from him because when they were fighting [Client #1] dug his fingers in [Client #2's] eyes and face. Then [Client #2] grabs the mop but I was able to get it from him before he hit [Client #1] with it. They stopped fighting but [Client #1] still was fussing and being very disrespectful to everyone including staff. [Group Home Manager] was called. [Client #1] still refused to go to his room.
-2/11/21 at 11:00am-Client (Client#1) stayed sleep in his room all morning until lunch time. Then client complained about what was being served for lunch and started calling me useless. I fixed his plate and told him to get his own plate so he started to attack everyone verbally calling clients and staff names. He banged on the kitchen table after I told clients to ignore him. He continue to bash clients and staff and tried to grab the mop out of staffs hand. Clients and staff continue to ignore him when he slapped [Client #2] in the face so they begin to fight. When they stopped fighting him and [Client #3] got into it. I told them to stop, they finally stopped. I made [Client #2] and [Client #3] to go into the living room and everything was calm except [Client #1] was still talking to him self and shouting then he flipped the kitchen table over and chairs. He continued to call me names and clients names talking about people family. Then [Former Staff #1] called to try and calm him down. PRN (as needed) was giving and client finally calmed down.
-3/27/21 at 9:30am-[Client #2] threatened to punch [Client #1] in the face while they were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

(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 290	Continued From page 27	V 290		

sitting in the room together. Soon after, [Client #1] asks staff for a bagle. [Client #1] goes into the kitchen and sees [Client #2] plate is on the table. [Client #1] tells [Client #2] his plate is on the table. [Client #2] tells [Client #1] he still wants the plate. [Client #2] then tells [Client #1] that he is going to tell [Staff #4] that [Client #1] has been acting funny. [Client #1] tells him no and says something about calling the cops. [Client #2] then tries to hit [Client #1], when he misses he grabs his arm and bit him for 10 seconds. Staff tells [Client #2] to go to his room then he pushes staff into the dinning room table and leaves out the house.
-03/22/21 at 9:30am-Client (client #1) was arguing with another client when I told them to go to their rooms. Neither did go. Client begin talking to me very disrespectfully so I took his tv out his room. As I walked by him with the tv he hit me on my legs and continue to disrespect me. That's when I called another staff and he finally went up to his room when he got ready. Then he began to beat on the walls and yell throughout the entire first shift.
-10/7/21 at 11:00am-After clients ate breakfast and took their meds, [Client #1] and [Client #2] begin to disagree on numerous things. They started talking about each others family members. Staff was at the desk when [Client #1] came to me and said he was going to wait until [Client #2] left the kitchen to fix him some pizza rolls because he didn't want to get into it with him at the time. So he sat in the living room with me. [Client #2] came from the kitchen to argue with [Client #1] about how he runs his mouth. [Client #2] then got closer to [Client #1]. I told them to stop before it goes any further. After they continued I threating to take their game systems. [Client #2] hits [Client #1] and I got up to try to break it up. They continued to fight and bite each

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

(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 290	Continued From page 28	V 290		

other. [Client #2] then gets up to grab a knife out the drawer I hurried behind him to the kitchen to stand in front of the drawer. Me and another client that wasn't involved in the fight quickly removed the sharp utensils to the closet to be locked up. Still trying to break up the fight [Client #2] runs to get a frying pan and begin to beat [Client #1] in the back with it. I backed away because he was swinging it wildly. Client that wasn't involved in the fight was able to grab the frying pan from [Client #2]. I made a phone call to manager so he could hear the comotion. Clients eventually got tired and stop fighting. [Client #1] continued to argue with staff and tried to knock kitchen table and chairs over then he was sent to his room and he begin to yell and punch walls until he eventually calmed down. Staff applied first aid to both clients scratches and bruises to both clients and made clients take showers to clean themselves up.
-Director met with [Client #2] on October 8, 2021 about an assault by his housemates (client #1). [Client #2] reported that client #1 had bitten him on his leg. [Client #2] was asked to show the Director the bit on his leg. The staff (Staff #1) stated that [Client #2] has bite mark on his arm as well. Director questioned [Client #2] about what happened to start the fight. [Client #2] said first that he did not know. [Client #2] then stated that client #1 wants his room, and he keeps coming into his room, trying to take possession of it. [Client #2] also noted that client #1 is angry because he wants to go on a home visit, and his grandfather won't like him. [Client #2] stated that client #1 stood at his door, and he told him to get out of his room, and client #1 fell in the room on him, causing him to fall on the floor, and client #1 bit him on the leg. [Client #2] stated that client #1 continued to try to take possession of his room, and he was trying to get client one out of his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

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V 290	Continued From page 29	V 290		

room, and he continued to attack and bite him. [Client #2] and staff stated that the client continued to try to assault [Client #2] for about 20 minutes. Staff called [Group Home Manager] for backup. The Director asked staff if she applied the first aid to the bites and scraps.
-[Client #1], the attacker, was interviewed by the Director about the incident. [Client #1] claimed he was unaware of the attack on his housemate. Then [Client #1] added, 'Oh yeah, I want his room right now.' [Client #1] blathered on and on about wanting to switch rooms with his roommate. [Client #1] makes holes in the walls and does not wish to remain in the room. The bite marks on [Client #1's] housemate led investigators to question [Client #1] about his attacks. [Client #1] lamented the fact that everyone despised him. [Client #1] was interested in everything but what he was being questioned about."

Observation on 10/08/21 at approximately 2:00pm revealed:
-Client #1 had a scratch above the left eye approximately half the size of his eye brow.
-Client #2 had a large area on the back of his right arm and the front of his right leg with apparent bite marks, bruising, redness and dried blood on the area.

During interview on 10/11/21 client #1 revealed:
-He and client #2 had a disagreement about food.
-He got mad with client #2 in the kitchen and he tried to sit down and client #2 hit him in the face.
-Staff #1 was in the living room.
-He bit client #3 in the butt and they were fighting in the floor.
-Staff #1 "just let us fight."
-His foot was hurting because client #2 bit him on top of his foot (He would not show surveyor bite mark).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

(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 290	Continued From page 30 -He and client #2 fight all the time. They were like brothers. During interview on 10/11/21 client #2 revealed: -He and client #1 got in a fight because of a Xbox game. -Client #1 bit him. -Staff #1 was in the living room and she did not break the fight up. -He bit client #1 on the foot. -Client #1 started the fight because he could not go home. -Client #1 bit him in the butt. -He threw the chair at client #1. During interview on 10/11/21 client #3 revealed: -Client #1 did not know how to keep his mouth shut. -The fight lasted over 20 minutes. -The fight started in the living room. -Staff #1 had ordered food and she was trying to break the fight up. -Staff #1 just let them fight because she did not want to get hurt. -Client #1 and client #2 fight all the time. During interview on 10/11/21 staff #1 revealed: -She worked first shift at the facility from 8:00a-4:00pm. -Client #1 and client #2 got in a fight on Thursday October 7, 2021. -Client #1 and client #2 always got into fights. -Client #1 would run his mouth to the other clients causing the arguments. -She was sitting in the living room when the altercation started. -Client #2 walked into the living room and stated client #2 had hit him with a chair. -She did not hear or see client #1 hit client #2 with a chair.	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

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V 290	Continued From page 31 -Client #2 started hitting client #1 and they both began to fight. -She told client #1 to go to his room and he refused. -She took client #1's game system and he became very angry. -Client #2 went into the kitchen and tried to get a knife out of the drawer and she blocked him from getting the knife. -Client #2 grabbed a frying pan and started hitting client #1. -Client #1 tried to flip the table over. -The fight was on and off most of the day and client #3 had to help her. -She had ordered food and Door Dash had delivered during the fight. -The whole day was full of drama. -She called the group home manager during the altercation to let him know what was going on. During interview on 10/13/21 the Group Home Manager revealed: -He was the manager of the facility and two other sister facilities. -The day of the fight he was with another client in another town. -Staff #1 called him and he told her to call the office for assistance. -He was not able to be everywhere and if staff need help they know to call the office. -He did not know why staff #1 did not call the office. -"It was hard to stop a fight and those clients are strong and it was hard to get them to calm down." -Any new staff that goes to the facility the clients will test them. -Client #2 had bite marks on his leg and arm. -He did not see any injuries on client #1. During interview on 10/13/21 the	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

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V 290	Continued From page 32 Licensee/Qualified Professional revealed: -She was not aware of the altercation that occurred on 10/07/21 until the following day. -She inquired with staff to make sure the first aid was administered on the wounds of the clients. -She asked the staff #1 what had happened and the staff responded that client #1 and client #2 had fought for over 20 minutes. -Client #2 did use to have a one-on-one worker until COVID in March 2020. -She was having a hard time finding staff to work. -She would ensure the facility had adequate staff to ensure the safety of the clients. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 290		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

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V 291	Continued From page 33 annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to maintain coordination between the facility operator and the professionals who are responsible for the client's treatment affecting 1 of 3 clients (#2). The findings are: Review on 10/13/21 of client #2's record revealed: -25 year old male. -Admission date of 12/03/10. -Diagnoses of Oppositional Defiant Disorder, Severe Mental Retardation and Encephalopathy. Review on 10/13/21 of client #2's record revealed the following information from the dentist dated 02/16/21: "-Fillings completed on #13-14 with tooth colored filling material. Unable to complete extraction on #15. Referred for additional treatment to oral surgion. See referral document." -Referral Document made to oral surgeon on 02/16/21. "Additional Comments: Ext(extraction) on #15 initiated, but tooth roots not removed 2/16/21."	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

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V 291	Continued From page 34 "-Medical Office Visit Form 7/26/21-Tx (treatment) today: Dental exam, cleaning...Follow Up Referral: Pt's (patient) caregiver was given a referral on 2-16-21 to [Oral Surgeon] to extract #15 root tips. He did not go. (illegible word) another referral." During interview on 10/11/21 client #2 was unable to recall any specific information about any doctor appointments. During interview on 10/13/21 the Group Home Manager revealed: -Staff #1 should have been the staff to take client #2 to the dentist. -He was not aware of the referral. During interview on 10/13/21 the Licensee/Qualified Professional revealed: -She had contacted client #2's Social Worker (SW) with the Department of Social Services (DSS) about client #2's referral. -Because client #2 had to be sedated for the procedure the DSS SW was going to have to get further permission from the DSS SW's supervisor. -She never heard anything else from client #2's DSS SW. -She did not make any other further contact with the social worker to determine if client #2 was able to get the procedure completed. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 291		
V 366	27G .0603 Incident Response Requirments	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

(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 35 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, 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	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

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V 366	Continued From page 36 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 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	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

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V 366	Continued From page 37 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. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement written policies for response to level I incidents of medications errors. The findings are: Review on 10/13/21 of client #1's record revealed: -24 year old male. -Admission date of 03/03/16. -Diagnoses of Depressive Disorder, Cerebral Palsy and Post Traumatic Stress Disorder. Review on 10/13/212 of client #1's July 2021 MAR revealed: -Omeprazole Dr 20mg had an X instead of initials from 07/22/21-07/26/21. -Risperidone 0.25mg had initials with a circle	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

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V 366	Continued From page 38 around on 07/19/21. -The back of the MAR was transcribed Risperidone and Omeprazole were not given on those dates because staff were waiting on refills. Review on 10/13/21 of facility records revealed no documentation of a Level 1 incident report was completed for the medication errors with client #1's Risperidone and Omeprazole on 07/19/21 and 07/22/21-07/26/21 and no corrective or preventive measures documented. During interview on 10/13/21 the Licensee/Qualified Professional revealed: -She had new staff in the facility and the old staff making the errors was no longer working at the facility. -She would ensure all staff were re-trained in medication administration and also re-trained when to contact the office for medication refills. -She would update the Level I incident report to include medication errors to include the pharmacy or doctor was contacted if the client missed a medication. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	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	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-912	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE II	1419 MILTON STREET SPRING LAKE, NC 28390

(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 39 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. (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	V 367		

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V 367	Continued From page 40 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 (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.	V 367		

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V 367	Continued From page 41 This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to report a critical incident to the home and host Local Management Entity (LME) within 72 hours as required. The findings are: Review on 10/13/21 of the North Carolina Incident Response Improvement System (IRIS) website revealed no level II incident reports had been submitted to the LME by the facility for the following incidents: -Emergency Room Visit Report dated 06/18/21-Reason for Visit-Assault. Diagnosis-Laceration of right eyebrow, initial encounter." -"10/7/21 at 11:00am-After clients ate breakfast and took their meds, [Client #1] and [Client #2] begin to disagree on numerous things. They started talking about each others family members. Staff was at the desk when [Client #1] came to me and said he was going to wait until [Client #2] left the kitchen to fix him some pizza rolls because he didn't want to get into it with him at the time. So he sat in the living room with me. [Client #2] came from the kitchen to argue with [Client #1] about how he runs his mouth. [Client #2] then got closer to [Client #1]. I told them to stop before it goes any further. After they continued I threating to take their game systems. [Client #2] hits [Client #1] and I got up to try to break it up. They continued to fight and bite each other. [Client #2] then gets up to grab a knife out the drawer I hurried behind him to the kitchen to stand in front of the drawer. Me and another client that wasn't involved in the fight quickly removed the sharp utensils to the closet to be locked up. Still trying to break up the fight [Client	V 367		

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V 367	Continued From page 42 #2] runs to get a frying pan and begin to beat [Client #1] in the back with it. I backed away because he was swinging it wildly. Client that wasn't involved in the fight was able to grab the frying pan from [Client #2]. I made a phone call to manager so he could hear the comotion. Clients eventually got tired and stop fighting. [Client #1] continued to argue with staff and tried to knock kitchen table and chairs over then he was sent to his room and he begin to yell and punch walls until he eventually calmed down. Staff applied first aid to both clients scratches and bruises to both clients and made clients take showers to clean themselves up. During interview on 10/13/21 the Licensee/Qualified Professional revealed: -She thought she had completed an incident report for the incident on 06/18/21. -She was unsure if the incident on 10/07/21 was a Level I or a Level II. -She would ensure she completed a Level II incident for both incidents. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 367		