Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL098-204	B. WING		11/1	8/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KYSEEM	'S UNITY GROUP HO	MF. LLC #5	E AVEUE NO NC 27893	DRTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
V 000	INITIAL COMMEN	тs	V 000			
	on November 18, 2	w up survey was completed 022. Deficiencies were cited.				
	This facility is licensed for the following category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.					
	This facility is licensed for 3 and has a census of 3. The survey sample consisted of audits of 3 current clients.					
V 108	27G .0202 (F-I) Pe	rsonnel Requirements	V 108			
	10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid					
	the American Hear	those provided by Red Cross, tAssociation or their eving airway obstruction.				

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED		
		MHL098	3-204	B. WING		11/1	8/2022
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KYSEEM	I'S UNITY GROUP HO	ME, LLC #5		E AVEUE NO NC 27893	DRTH		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC ^N REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 108	(i) The governing to implement policies reporting, investiga and communicable clients.	oody shall deve and procedure ting and contro diseases of p	es for identifying, olling infectious ersonnel and	V 108			
	This Rule is not met as evidenced by: Based on record reviews, observations and interviews, the facility failed to provide training to meet the needs of the clients for 3 of 3 direct care staff audited (Staff #1, Staff #3 and staff #4). The findings are:						
	Review on 11/17/22-24 year old male -Admission date 2/ -Diagnoses include Hyperactivity Disord Developmental Dis Pervasive Develop Disorder, Sleep Api disease (GERD)Continuous positiv machine used at as support assessmen	10/22 ad Autism, Atteder, Moderate ability, Seizure mental Disorde nea, gastroese se airway press sindicated in r	ntion Deficit Intellectual Disorder, er, Mood ophageal reflux				
	Review on 11/17/22 revealed: -Hire date, 10/8/21 -No documentation CPAP cleaner and	of training on	CPAP, or the				
	Review on 11/17/22 revealed: -Hire date, 8/24/19	2 of staff #3's բ	personnel file				

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED		
		MHL098-204		B. WING		11/·	18/2022
	PROVIDER OR SUPPLIER	ME, LLC #5	304 CLYD	DRESS, CITY, S E AVEUE NO NC 27893	STATE, ZIP CODE DRTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCI MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 108	-No documentation CPAP cleaner and serview on 11/17/22 revealed: -Hire date, 3/5/17 -No documentation CPAP cleaner and serview on 11/18/2-Client #2 had the Cadmitted and alreaditHe would ensure service CPAP machineThere had been not use of the CPAP machine.	of training on CPA sanitizer machine. of staff #4's person of training on CPAI sanitizer machine. 22 the Licensee stace CPAP machine prior dy knew how to use staff received training adverse incidents	nnel file or, or the ted: to being and clean g on the with the	V 108			
V 111	27G .0205 (A-B) Assessment/Treatn 10A NCAC 27G .02 TREATMENT/HAB PLAN (a) An assessment client, according to the delivery of servi be limited to: (1) the client's pres (2) the client's nee (3) a provisional or established diagnos of admission, excep detoxification or oth shall have an estab admission; (4) a pertinent soci and (5) evaluations or a	205 ASSESSME ILITATION OR SER It shall be completed governing body polices, and shall inclu senting problem; ds and strengths; admitting diagnosis sis determined within of that a client admi ner 24-hour medical dished diagnosis up	int AND eVICE d for a icy, prior to de, but not s with an in 30 days tted to a program on	V 111			

Division of Health Service Regulation

STATE FORM 6899 KJUO11 If continuation sheet 3 of 12

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		SURVEY PLETED		
		MHL098-204		B. WING		11/1	18/2022
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KYSEEM	I'S UNITY GROUP HO	ME, LLC #5		E AVEUE NO NC 27893	ORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENC Y MUST BE PRECEDED E SC IDENTIFYING INFORI	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
V 111	Continued From particles psychiatric, substant vocational, as approximately (b) When services establishment and treatment/habilitation referred to as the "I client's presenting processing of the continuation of the continuatio	nce abuse, medical opriate to the client are provided prior implementation of ton or service plan, I blan," strategies to	's needs. to the the nereafter address the	V 111			
	This Rule is not me Based on record refacility failed to come assessment for 1 of findings are: Review on 11/17/22 - 22 year old female Diagnoses included Mild Intellectual De No completed adress primary diagnosis. During interviews of There were no addients #1. He has set an appear an assessment come This deficiency come and must be corrected.	eviews and interview replete an admission of 3 audited clients (2 of client #1's record admitted 11/13/22 and Autism Spectrum velopmental Disabinission assessments of a developmental n 11/17/22 License mission assessments on assessments on a sessment and the properties of a development and the development	vs the n (#1). The rd revealed: I. n Disorder, ilities nt identifying al disability. re stated: nts for #1 to get				

Division of Health Service Regulation

STATE FORM 6899 KJUO11 If continuation sheet 4 of 12

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	X2) MULTIPLE CONSTRUCTION (X3) DATE COMF			
		MHL098-204	B. WING		11/	18/2022
	PROVIDER OR SUPPLIER	OME 11.C.#5	EET ADDRESS, CITY, S CLYDE AVEUE NO SON, NC 27893			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 112	10A NCAC 27G .02 TREATMENT/HAB PLAN (c) The plan shall is assessment, and in legally responsible of admission for clireceive services be (d) The plan shall is (1) client outcome (achieved by provisi projected date of ac (2) strategies; (3) staff responsible (4) a schedule for annually in consultar responsible person (5) basis for evaluation outcome achievem (6) written consent responsible party, oprovider stating why obtained.	be developed based on the partnership with the clien person or both, within 30 cents who are expected to eyond 30 days. include: (s) that are anticipated to be ion of the service and a chievement; le; review of the plan at least ation with the client or legal or both; ation or assessment of ent; and to ragreement by the client or a written statement by the y such consent could not be	e t or days de lly			
	facility failed to dev	et as evidenced by: eviews and interviews, the elop and implement goals ss client needs for one of t				

Division of Health Service Regulation

STATE FORM 6899 KJUO11 If continuation sheet 5 of 12

Division of Health Service Regulation

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MIII 000 204	B. WING		44/40/0000	
		MHL098-204	D. WINO		11/18/2022	-
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
KYSEEM	'S UNITY GROUP HO	MF IIC#5	DE AVEUE NO NC 27893	ORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLÉ	
V 112	-24 year old male -Admission date 2/2 -Diagnoses included Hyperactivity Disord Developmental Disa Pervasive Developmental Disa Interview on Strategory Interview on 11/18/2 -He used his CPAP -He knew how to cle Interview on 11/17/2 -He cleaned client # Interview on 11/18/2 -Staff #4 cleaned client # Undated to include to updated to include to updated to include to the facility purchase client #2's CPAP mas	The findings are: 2 of client #2's record revealed: 10/22 d Autism, Attention Deficit der, Moderate Intellectual ability, Seizure Disorder, mental Disorder, Mood nea, gastroesophageal reflux e airway pressure (CPAP) indicated in risk needs nt. gies to address client #2's use ne. 22 client #2 stated: machine nightly. ean his CPAP machine. 22 staff #4 stated: #2 CPAP machine weekly. 23 the Licensee stated: ient #2' CPAP machine dient #2's treatment plan was the CPAP machine. stitutes a re-cited deficiency	V 112			
V 114		ncy Plans and Supplies	V 114			
	10A NCAC 27G .02 AND SUPPLIES	07 EMERGENCY PLANS				

6899

Division of Health Service Regulation STATE FORM

KJUO11 If continuation sheet 6 of 12

Division of Health Service Regulation

V 114 Continued From page 6 (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure fire and disaster drills were held at least quarterly and repeated on each shift under conditions that simulate fire emergencies. The findings are: Review on 11/17/22 of facility records for October 2021 thru October 2022 revealed: Fire Drills: Only one fire drill (8:00pm) for the October 2021 quarter was documented. No fire drills prior to 1:00pm or after 5:00pm for the January 2022 - March 2022 quarter were documented. No fire drills prior to 5:30pm or after 6:00pm for the April 2022 - June 2022 quarter were documented. No fire drills prior to 3:00pm or after 4:30pm for July 2022 - October 2022 were documented. Disaster Drills:	STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
CALL CALL			MHL098-204	B. WING		11/1	8/2022
(X4) D SUMMARY STATEMENT OF DEFICIENCIES TAG SUMMARY STATEMENT OF DEFICIENCY MIST BE PRECEDED BY FULL PREFIX TAG SUMMARY STATEMENT OF DEFICIENCY MIST BE PRECEDED BY FULL PREFIX RESULATORY OR LSC BENTFYING INFORMATION) PREFIX TAG PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCY ACTION SHOULD BE CROSS-REFERENCY. V114	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) V 114 Continued From page 6 (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure fire and disaster drills were held at least quarterly and repeated on each shift under conditions that simulate fire emergencies. The findings are: Review on 11/17/22 of facility records for October 2021 thru October 2022 revealed: Fire Drills: Only one fire drill (8:00pm) for the October 2021 - December 2021 quarter was documented. No fire drills prior to 1:00pm or after 5:00pm for the January 2022 - March 2022 quarter were documented. No fire drills prior to 5:30pm or after 6:00pm for the April 2022 - June 2022 quarter were documented. No fire drills prior to 3:00pm or after 4:30pm for July 2022 - October 2022 were documented. Disaster Drills:	KYSEEM	I'S UNITY GROUP HO	MF. LLC #5		DRTH		
(a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interviews the facility falled to ensure fire and disaster drills were held at least quarterly and repeated on each shift under conditions that simulate fire emergencies. The findings are: Review on 11/17/22 of facility records for October 2021 thru October 2022 revealed: Fire Drills: Only one fire drill (8:00pm) for the October 2021 December 2021 quarter was documented. No fire drills prior to 1:00pm or after 5:00pm for the January 2022 - March 2022 quarter were documented. No fire drills prior to 5:30pm or after 6:00pm for the April 2022 - June 2022 quarter were documented. No fire drills prior to 3:00pm or after 4:30pm for July 2022 - October 2022 were documented. No fire drills prior to 3:00pm or after 4:30pm for July 2022 - October 2022 were documented. Disaster Drills:	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
the April 2022 - June 2022 quarter were documentedNo fire drills prior to 3:00pm or after 4:30pm for July 2022 - October 2022 were documented. Disaster Drills:	V 114	(a) A written fire plaarea-wide disaster shall be approved be authority. (b) The plan shall be and evacuation proposted in the facility (c) Fire and disaster shall be held at least repeated for each sunder conditions the (d) Each facility shat accessible for use. This Rule is not mead accessible for use. Review on 11/17/22 accessible for use. Review on 11/17/22 accessible for use. Review on 11/17/22 accessible for use.	an for each facility and plan shall be developed and by the appropriate local or made available to all staff cedures and routes shall be expected at simulate fire emergencies. The and disaster drills were held at simulate fire emergencies and have basic first aid supplies and disaster drills were held and repeated on each shift at simulate fire emergencies. 2 of facility records for October 2022 revealed: 8:00pm) for the October 2021 quarter was documented. o 1:00pm or after 5:00pm for March 2022 quarter were	V 114	DEFICIENCY)		
-No disaster drills for before or after 6:00pm were		documentedNo fire drills prior July 2022 - Octobe Disaster Drills:	to 3:00pm or after 4:30pm for r 2022 were documented.				

Division of Health Service Regulation

STATE FORM 6899 KJUO11 If continuation sheet 7 of 12

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE SUR COMPLETI					
		MHL098-204		B. WING		11/	18/2022
NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
KYSEEM	'S UNITY GROUP HO	ME, LLC #5		E AVEUE NO NC 27893	DRTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCI MUST BE PRECEDED B' SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 114	Continued From pa	ge 7		V 114			
	documented for the quarterNo disaster drills d June 2022 quarterOnly one disaster of July 2022 - October	ocumented for the A	April 2022 -				
	Interview on 11/17/2 - He had been in a were some fire drill not been filedAll other fire and dibeen provided for the	vehicular accident forms in his vehicle isaster drill docume	that had ntation had				
	Interview on 11/17/2 -Shifts at the facility 4:30pm - 7:00am at 7:00am - 7:00pm at -He understood the disaster drills were quarterly and repeat conditions that simulated	were Monday - Friond Weekend shifts on 7:00pm - 7:00am requirement that fire to be completed at ted on each shift ur	day were n. re and least nder				
	This deficiency con and must be correct		eficiency				
V 289	27G .5601 Supervis	sed Living - Scope		V 289			
	10A NCAC 27G .56 (a) Supervised livir provides residential home environment these services is the rehabilitation of indifference abuse of a substance abuse supervision when in (b) A supervised livit the facility serves en	ng is a 24-hour facilic services to individually where the primary pecare, habilitation of viduals who have a ental disability or disse disorder, and who the residence.	ials in a burpose of or mental sabilities, o require				

Division of Health Service Regulation

STATE FORM 6899 KJUO11 If continuation sheet 8 of 12

Division of Health Service Regulation

AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:			COMPL	SURVEY
		A. BUILDING:		COMPL	-ETED
	MUI 000 204	B WING		44/4/	0/2022
	MHL098-204	D. WING		11/18	8/2022
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KYSEEM'S UNITY GROUP HOM	IF 11C #5	E AVEUE NO	DRTH		
	WILSON,	NC 27893		T	
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETE DATE
V 289 Continued From page	e 8	V 289			
(1) one or more (2) two or more Minor and adult client same facility. (c) Each supervised licensed to serve a special designated below: (1) "A" designated serves adults whose pillness but may also here (2) "B" designated serves minors whose developmental disabilitiagnoses; (3) "C" designated serves adults whose period developmental disabilitiagnoses; (4) "D" designated serves minors whose substance abuse depother diagnoses; (5) "E" designated serves adults whose period serves adult clients whose period serves adult clients whome adisabilities, or three adult clients whose primary developmental disabilities who family provides the see exempt from the follor.0201 (a)(1),(2),(3),(4)	e minor clients; or e adult clients. Its shall not reside in the living facility shall be pecific population as ation means a facility which primary diagnosis is mental nave other diagnoses; ation means a facility which e primary diagnosis is a ility but may also have other ation means a facility which primary diagnosis is a ility but may also have other ation means a facility which primary diagnosis is a ility but may also have other ation means a facility which primary diagnosis is bendency but may also have ation means a facility which primary diagnosis is bendency but may also have ation means a facility in a nich serves no more than nose primary diagnoses is a also have other adult clients or three minor y diagnoses is ilities but may also have other adult clients or three minor y diagnoses is ilities but may also have other adult clients or three minor y diagnoses is ilities but may also have other adult clients or three minor y diagnoses is ilities but may also have other adult clients or three minor y diagnoses is ilities but may also have other adult clients or three minor y diagnoses is ilities but may also have other adult clients or three minor y diagnoses is ilities but may also have	V 209			

Division of Health Service Regulation

STATE FORM 6899 KJUO11 If continuation sheet 9 of 12

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	MHL098-204	B. WING	11/18/2022

'S UNITY GROUP HOME 11C #5		RTH	
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) COMPLETI DATE
Continued From page 9	V 289		
(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 review and interviews the facility failed to meet the scope of the license by admitting an individual without a primary diagnosis of a developmental disability. The findings are:			
Review on 11/16/22 of the facility's license revealed it was licensed as a 10A NCAC 27G .5600C Supervised Living for Adults With Developmental Disabilities.			
Review on 11/17/22 of client #1's record revealed: - 22 year old female admitted 11/13/21 Diagnoses included Autism Spectrum Disorder, Mild Intellectual Developmental Disabilities No completed admission assessment identifying a primary diagnosis of a developmental disability.			
During interviews on 11/17/22 Licensee stated: - There were no admission assessments for clients #1 He has set an appointment for client #1 to get an assessment completed.			
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 (i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 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 review and interviews the facility failed to meet the scope of the license by admitting an individual without a primary diagnosis of a developmental disability. The findings are: Review on 11/16/22 of the facility's license revealed it was licensed as a 10A NCAC 27G .5600C Supervised Living for Adults With Developmental Disabilities. Review on 11/17/22 of client #1's record revealed: - 22 year old female admitted 11/13/21. - Diagnoses included Autism Spectrum Disorder, Mild Intellectual Developmental Disabilities. - No completed admission assessment identifying a primary diagnosis of a developmental disability. During interviews on 11/17/22 Licensee stated: - There were no admission assessments for clients #1. - He has set an appointment for client #1 to get	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 (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 review and interviews the facility failed to meet the scope of the license by admitting an individual without a primary diagnosis of a developmental disability. The findings are: Review on 11/16/22 of the facility's license revealed it was licensed as a 10A NCAC 27G .5600C Supervised Living for Adults With Developmental Disabilities. Review on 11/17/22 of client #1's record revealed: - 22 year old female admitted 11/13/21 Diagnoses included Autism Spectrum Disorder, Mild Intellectual Developmental Disabilities No completed admission assessment identifying a primary diagnosis of a developmental disability. During interviews on 11/17/22 Licensee stated: - There were no admission assessments for clients #1 He has set an appointment for client #1 to get	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 (i): 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a)(b): 10A NCAC 27G .0207 (b),(c); 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 review and interviews the facility failed to meet the scope of the license by admitting an individual without a primary diagnosis of a developmental disability. The findings are: Review on 11/16/22 of the facility's license revealed it was licensed as a 10A NCAC 27G .5600C Supervised Living for Adults With Developmental Disabilities. Review on 11/17/22 of client #1's record revealed: - 22 year old female admitted 11/13/21 Diagnoses included Autism Spectrum Disorder, Mild Intellectual Developmental Disabilities. Review on 11/17/22 Licensee stated: - There were no admission assessments for client #1 He has set an appointment for client #1 to get

STATE FORM 6899 If continuation sheet 10 of 12 KJUO11

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMPI		
		MHL098-204	B. WING		11/1	8/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KYSEEM	I'S UNITY GROUP HO	MF. LLC #5	E AVEUE NO NC 27893	DRTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 289	Continued From pa	ge 10	V 289			
	and must be correct	ted within 30 days.				
V 736	27G .0303(c) Facili	ty and Grounds Maintenance	V 736			
	EXTERIOR REQUI (c) Each facility and maintained in a safe	603 LOCATION AND REMENTS I its grounds shall be e, clean, attractive and orderly e kept free from offensive				
		ons and interviews, the facility in a clean, attractive and				
	11:00am of the faci -The kitchen light of -The linoleum on the stove was tornBrown stains on the -Blind over kitchen -Dead bugs in freeze -Microwave had rust -Approximately 2 in door leading into the cracked on the side -Heavy dust on ceil -Client #1 had heave -Client #3's 5 draw on the first drawer of -The cabinet door we bathroom; linoleum	ver the stove was not working. e floor on the left side of the e floor beside the stove. sink had broken slats. zer. st spots inside it. ch hole in the front side of the e kitchen; door was also e. ing vent in the hallway. ry dust on his nightstand. er dresser had 1 knob missing				

6899

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
MHL098-20		ļ	B. WING		11/18/2022			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
KYSEEM'S UNITY GROUP HOME, LLC #5 304 CLYDE AVEUE NORTH 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 CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	RRECTIVE ACTION SHOULD BE COMPLETE ERENCED TO THE APPROPRIATE DATE		
V 736	Continued From pathead was loose fro Client #1's window Interview on 11/22/stated: -He understood the maintained in a clemanner. This deficiency con and must be correct	m wall. sill was dirty. 22 the Group Home facility was required an, attractive and eastitutes a re-cited	red to be orderly	V 736	DELITORITY			

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