

RECEIVED

MAY 01 2023

PRINTED: 04/18/2023  
FORM APPROVED

Division of Health Service Regulation

DMH MHI Licensure Sect

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-898</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/11/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>NC UNITY SERVICES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3105 VICO TERRACE RALEIGH, NC 27610</b>
--	---

(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)	(X6) COMPLETE DATE
V 000	<p><b>INITIAL COMMENTS</b></p> <p>An on-site survey was completed on 4/11/23. A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p> <p>This facility is licensed for 3 and currently has a census of 0. The survey sample consisted of audits of 2 discharged clients who are now admitted to a facility operated by a different licensee in a neighboring county.</p> <p>This report references a licensed facility operated by a different licensee which is located in a neighboring county. This facility will be identified as Facility A. Staff from the facility will be identified using the letter of the facility &amp; a numerical identifier. The 2 discharged clients will be identified in relation to their current licensed facility using the letter of the facility &amp; a numerical identifier.</p>	V 000	<p><i>NC Unity Services has successfully provided Residential Supports Services to two (2) Innovation Wavier clients for many years. NC Unity Services has always follow all of The Division of Health Services Regulations with the expectation of honoring our State License MHL 092-898 with no deficiencies. NC Unity Services took</i></p>	<p><i>V000</i></p>
V 289	<p><b>27G .5601 Supervised Living - Scope</b></p> <p>10A NCAC 27G .5601 SCOPE</p> <p>(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.</p> <p>(b) A supervised living facility shall be licensed if the facility serves either:</p> <p>(1) one or more minor clients; or</p> <p>(2) two or more adult clients.</p> <p>Minor and adult clients shall not reside in the</p>	V 289	<p><i>(Continuation of handwritten text from previous row)</i></p>	<p><i>(Continuation of handwritten text from previous row)</i></p>

Division of Health Service Regulation  
LABORATORY

AGENT'S SIGNATURE

TITLE

(X6) DATE

*Administrator*

*4/26/2023*

STATE FORM

6899

880011

If continuation sheet 1 of 5

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-898</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/11/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>NC UNITY SERVICES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3105 VICO TERRACE RALEIGH, NC 27610</b>
--	---

(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	<p><i>Continued From page 1</i></p> <p>same facility.</p> <p>(c) Each supervised living facility shall be licensed to serve a specific population as designated below:</p> <p>(1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses;</p> <p>(2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses;</p> <p>(3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses;</p> <p>(4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses;</p> <p>(5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or</p> <p>(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)&amp;(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) -</p>	V 289	<p><i>the proper steps to end the Residential Supports Services at 3105 Vico Terrace Raleigh NC on February 28th, with clear expectations for Inez's House LLC, LLC to take over as of March 1, 2023 with the ability to accurately provide the care to the two Innovation Wavier Clients.</i></p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-898</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/11/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>NC UNITY SERVICES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3105 VICO TERRACE RALEIGH, NC 27610</b>
--	---

(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	<p>Continued From page 2</p> <p>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).</p> <p>This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to provide services within the scope for which they are licensed. The findings are:</p> <p>Review on 4/11/23 of a faxed discharge summary to the Division of Health Service Regulation (DHSR) dated 4/11/23 from the Licensee revealed the following: - clients #A1 &amp; #A2 were discharged as of 3/1/23 to Facility A</p> <p>Review on 4/11/23 of a fax dated 4/10/23 from Facility A's Licensee revealed the following: An admission assessment dated 3/1/23 for client #A1 &amp; client #A2 - diagnosis of Autism</p> <p>Observation on 4/10/23 at 12:36pm revealed the following: - client #A1 was on the couch with legs folded rocking back &amp; forth - he made a grunting noise when greeted - television was on - staff #A1 present with client #A1</p> <p>During interview on 4/10/23 staff #A1 reported: - started working at Facility A on 3/1/23</p>	V 289	<p><i>NC Unity Services Completed and provided the supported documents/information to The Division of Health Services Regulations, the document of Change of Ownership (CHOW) was submitted with all signatures supporting the change as well as a Discharged Summary of the clients from NC Unity Services Care.</i></p>	<p><i>V000 11/28/23</i></p>
-------	--	-------	---	---------------------------------

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-898</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/11/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>NC UNITY SERVICES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3105 VICO TERRACE RALEIGH, NC 27610</b>
--	---

(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	<p>Continued From page 3</p> <ul style="list-style-type: none"> <li>- Facility A Licensee's husband brought him &amp; the clients to the facility every morning between 6am &amp; 6:30am to meet the day program transportation van &amp; returned to pick them up around 3pm</li> <li>- they have done this since 3/1/23</li> <li>- client #A1's transportation to the day program did not show this morning to pick him up</li> <li>- client #A2 was currently at his day program</li> <li>- he texted Facility A Licensee this morning to make them aware client A#1's transportation did not show, but had not heard back from Facility A's Licensee</li> <li>- was the first time client #A1's transportation driver did not show</li> <li>- he and client #A1 watched television</li> <li>- clients' records and medications were at Facility A</li> </ul> <p>During interview on 4/11/23 the Licensee from Facility A Licensee reported:</p> <ul style="list-style-type: none"> <li>- was in the process of completing a Change of Ownership (CHOW) to take over this facility</li> <li>- was "just" made aware client #A1's transportation did not show this morning</li> <li>- clients #A1 &amp; #A2 resided in the facility prior to the initiation of the CHOW</li> <li>- no services were being provided at the facility</li> <li>- clients currently resided at Facility A</li> <li>- clients only went to the facility in the morning for transportation to the day program</li> <li>- her husband dropped them off at the facility in the morning &amp; picked them up in the afternoon</li> </ul> <p>During interview on 4/11/23 the Licensee reported:</p> <ul style="list-style-type: none"> <li>- received confirmation from DHSR that an application for a CHOW was being processed</li> <li>- had not received confirmation the CHOW was completed</li> </ul>	V 289	<p>Please be advised that VOOO NC Unity Services was V289 informed by the administrator of Inez's House LLC that NO further assistance was required from this provider after making several attempts to assist in effort to make the transitioning as smooth as possible. The new provider is currently renting the unit from me (BC) and a lease agreement was provided and agreed upon.</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-898</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/11/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  
**NC UNITY SERVICES**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**3105 VICO TERRACE  
RALEIGH, NC 27610**

(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	<p>Continued From page 4</p> <ul style="list-style-type: none"> <li>- she gave the facility's keys to Facility A Licensee but was not aware she brought staff &amp; clients to the facility daily since 3/1/23</li> <li>- thought Facility A Licensee took the clients directly to the day program from Facility A</li> <li>- will call Facility A Licensee &amp; request staff &amp; clients not to return to the facility until the CHOW is completed</li> </ul>	V 289	<p>NC Unity Services had NO further involvement with the transitioning of the clients into the new provider organization/ care and assumed that all entities was handle accordingly. NC Unity Services was informed of the current situation and informed the current provider that absolutely NO services share be render</p>	<p>V000 V289</p>

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-898</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/11/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>NC UNITY SERVICES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3105 VICO TERRACE RALEIGH, NC 27610</b>
--	---

(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	<p>Continued From page 4</p> <ul style="list-style-type: none"> <li>- she gave the facility's keys to Facility A Licensee but was not aware she brought staff &amp; clients to the facility daily since 3/1/23</li> <li>- thought Facility A Licensee took the clients directly to the day program from Facility A</li> <li>- will call Facility A Licensee &amp; request staff &amp; clients not to return to the facility until the CHOW is completed</li> </ul>	V 289	<p>to the Innovation Waiver clients at any time until the House has been licensed under the Provider's name.</p> <p>I continue to monitor to ensure that this matter is dissolved as soon as possible without any further discretions as well as no violations relating to the license under NC Unity Services.</p>	<p>V000 V289</p>

*Continue* →