	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SU IDENTIFICATIO		` ′			DATE SURVEY COMPLETED	
		MHL098-1	98	B. WING		R — <b>12/20</b> /2		
NAME OF F	PROVIDER OR SUPPLIER	•	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	·		
KYSEEM	I'S UNITY GROUP HO	ME LLC #4		ORO STREE	ET E			
(VA) ID	STIMMADV STA	TEMENT OF DEFICIE		NC 27893	PROVIDER'S PLAN OF COR	PECTION	(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDE SC IDENTIFYING INF	D BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
V 000	INITIAL COMMENT	ΓS		V 000				
	An annual, complai completed on Dece complaint was unsu #NC00225245). A	ember 20, 2024. ubstantiated (Inta deficiency was c	The ake sited.					
	This facility is licens category: 10A NCA Living for Adults wit	AC 27G .5600C	Supervised					
	This facility is licens census of 4. The s audits of 3 currents	urvey sample co						
V 736	27G .0303(c) Facili	ty and Grounds	Maintenance	V 736				
	10A NCAC 27G .03 EXTERIOR REQUI (c) Each facility and maintained in a safe manner and shall b odor.	REMENTS I its grounds sha e, clean, attractiv	all be ve and orderly					
	This Rule is not me Based on record re interviews the facilit safe, clean, attractiv offensive odors. The	view, observatio ty was not maint ve manner and f	ns and ained in a					
	Observation on 12/2 am-9:25 am a tour -The front porch ha and a chair with browas a wasp nest at -The ceiling fan in tour light bulbs not -Client #1 had one and two golfball size from the floor, the closet door near	of the facility revided a brown couch oken arm to the roove the couch, he living room howorking, softball size, two e areas of missing door handle was	realed: In to the left right and there ad two out of It baseball size and linoleum missing on					

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

(X6) DATE TITLE

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:	A. BUILDING:		 	
		MHL098-198	MHL098-198 B. WING		R <b>12/20/2024</b>		
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
KYSEEM	'S UNITY GROUP HO	METIC #4	ORO STREE	T E			
	0.111.41.45.77.45.77.4		NC 27893				
(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 SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE	
V 736	Continued From pa	ige 1	V 736				
	six drawers were management of the room.  -Client #3 had three the dresser on the start was missing two outled three knobs missing side of the room.  -Client #3 had three three knobs missing side of the room.  -Client #4 had top referser, three out of fan and the top half approximately 6 incention.  -Back hallway near window with metal and heavy dust on the the bathroom.  -The bathroom.  -The bathroom sink, the molding at the base discoloration, wall the crack approximately around the base of was around the entention.  -The kitchen left be hinge, door would regap, oven handle wout of four drip pan rusted, cabinet und missing knobs on a some detector had 15 seconds.  Interview on 12/20/	dissing handles from dresser. of four light bulbs on the ceiling and, lamp near the entrance and the dresser drawer at of nine knobs from the entropy of the cout of six drawers missing on left side of the room and two of gon the dresser on the right drawer missing on the dresser on the right of four missing bulbs in cling for the door had a crack ches long.  I a foul smell coming from the sink had a slow drain, shoe end the tub had dark ander the left window has a sink had a slow drain, shoe end the showerhead and rusting the shower rod. It is sh					
	-She had been wor years.	king at the facility for five					

Division of Health Service Regulation

issues and he reports it to the landlord.

STATE FORM SLKG11 If continuation sheet 2 of 4

	UT OF DEFICIENCIES	l ·	(VO) MULTIPL	E CONOTRILOTION	LOVON DATE	OLIDVEY.
	FATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONS ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
			A. BUILDING:		33m LL1LD	
				R		
	MHL098-198		B. WING		12/20/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
10/0==1		408 TARE	ORO STREE	TE		
KYSEEM	I'S UNITY GROUP HO	OME LLC #4 WILSON,	NC 27893			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON O	(X5)
PRÉFIX	<b>`</b>	FICIENCY MUST BE PRECEDED BY FULL DRY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		D BE	COMPLETE	
TAG	REGULATORY OR L			PRIATE	DATE	
				,		
V 736	Continued From pa	ge 2	V 736			
	Interview on 12/20/	24 with staff #2 stated:				
	-She had been wor	king at the facility for almost 5				
	years.					
		aintenance request was to				
		the Director and he will put a				
	work order in to have					
	maintenance issues	gement of client #1 bedroom				
		ced the battery on 12/16/24.				
		ualified Professional (QP) that				
		a new smoke detector.				
		n had an electrical shortage.				
		a hole in his bedroom door				
	about two months a	ago.				
	Interview on 12/20/	24 with the QP stated:				
		QP for a few months.				
		facility visits to see the clients.				
		ssues had been reported to her				
	by staff.	·				
		e of the electrical shortage with				
	Client #2 ceiling far					
		vater smell was an issue with				
		a and the house being older. the local water department				
		ger to report the maintenance				
	issues.	ger to report the maintenance				
		24 the Lead QP stated:				
		king at the facility for about 7				
	years.					
	-She was not aware with client #2 fan.	e of the maintenance issue				
		aintenance issues to the				
	director.	annonance issues to the				
	Interview on 12/20/	24 with the Director stated:				
		of the electrical shortage in				
	client #1 ceiling fan					

Division of Health Service Regulation

STATE FORM SLKG11 If continuation sheet 3 of 4

AND PLAN OF CORRECTION   IDENTIFICATION NUMBER:   A. BUILDING:   COMPLETED    R	
12/20/20	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
	AME OF PROV
KYSEEM'S UNITY GROUP HOME LLC #4  408 TARBORO STREET E WILSON, NC 27893	YSEEM'S U
(X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COME TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PREFIX
V 736 Continued From page 3 -The Lead QP and the QP went to visit the facility weeklyHe would report the maintenance concerns to the landlord for repair.	-Th we -He

6899

Division of Health Service Regulation STATE FORM