STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL064-161	A. BUILDING: _____ B. WING _____	R 07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOODY HEALTH CARE SERVICES INC II	601 COLBY COURT ROCKY MOUNT, NC 27803

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V 000	INITIAL COMMENTS An annual and follow up survey was completed on 7/2/25. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. The facility is licensed for 5 and currently has a census of 5. The survey sample consisted of audits of 3 current clients.	V 000		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented.	V 111	RECEIVED BY MHL & C 8/18/25	

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V 111	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure an admission assessment for 1 of 3 audited clients (#1) was completed prior to delivery of services. The findings are: Review on 6/30/25 client #1's record revealed: - Admitted: 4/11/25 - Diagnoses: Schizoaffective Disorder, Psychosis, Hypertension, Fetal Alcohol Symptoms, Cognitive Impairment - No documentation of an admission assessment Interview on 7/1/25 the acting Qualified Professional (QP) reported: - The facility had another QP on record as their permanent QP but that QP had been out on medical leave so she had been acting QP since March of 2025 - As acting QP, she had met with clients, visited the facility and completed trainings with staff - She had not been responsible for completing any client documentation, including admission assessments Interview on 6/30/25 the Supervisor reported:	V 111	Corrective Action: Admission deficiency -As of 7/2/2025 an admission assessment was completed and placed in the consumer's chart. -The clinical team reviewed the assessment with the consumer and updated the person-centered plan accordingly. -A full audit of all current consumer records was conducted on 7/2/2025 to ensure admission assessments are on file. -No other consumers were found to be missing admission assessments. If any had been completed immediately. -A new admission checklist has been implemented, effective 7/7/2025, to be completed at intake and reviewed by the QP within 48 hours. -Admission assessments will now be completed within 72 hours of intake and must be signed by a QP before service delivery begins. -Staff involved in admissions (QP) received retraining on 27G.0205 (A-B) on 7/7/2025. Documentation of this training is on file. -QP and/or House manager will conduct random monthly audits of 25% of all new admissions to ensure compliance with all admissions. -QP and/or house manager will review consumer charts quarterly. Any deficiencies will be corrected immediately. -Ongoing training will be conducted annually or when needed for involved staff.	

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V 111	Continued From page 2 - The QP for the facility had been out on medical leave - They had an acting QP but she had not been completing any client documentation - Client #1's admission assessment was not completed due to the QP being unable to work at the time client #1 was admitted - The QP had resumed completing client documentation, including admission assessments, but was still not able to come to the facility in person Interview on 6/30/25 the Administrator reported: - The facility's QP was out on medical leave and there was an acting QP in place since March 2025 - She was not aware client #1's admission assessment was not completed	V 111	-The QP completed and signed the missing admission assessment for the consumer on 7/1/2025. -The responsible staff were notified of the deficiency and immediate documentation protocols were enforced. -A full chart audit of all consumers admitted within the last 90 days was completed on 7/30/2025 to ensure all admission assessments are present and complete. -No additional consumers were found to be affected. If any had been identified, immediate assessments would have been completed. - a backup QP protocol has been implemented. When a QP is on medical leave etc., a designated alternative QP will be assigned to review and approve all admissions and ensure assessments are completed. -The admission process has been revised. All new admissions will signify a notification to the QP to ensure admission goes unnoticed during staff absences. -All staff responsible for intake including administrative personnel, will be informed on updates on admission protocol and documentation required for admission. -An admission checklist has been added to each consumer file and must be reviewed and signed by QP or alternative staff within 72 hours of admission.	

			-After 60 days QP or house management will review 25% of admissions monthly. -Any issues identified during audits or review will result in immediate correction of the file. Completion date for compliance: 7/30/2025	
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) Each facility shall develop a written fire plan and a disaster plan and shall make a copy of these plans available to the county emergency services agencies upon request. The plans shall include evacuation procedures and routes. (b) The plans 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 the facility's response to fire emergencies.	V 114	Corrective Action: Fire & Disaster deficiency -All 3rd shift staff will be retrained on emergency protocols, the importance of shift-specific drills and documentation procedures. -A full review of all shift-specific drill documentation for the home will be conducted every quarter. -any missing drills or documentation will be addressed by conducting make-up drills and properly filing all required records. -A drill log tracking system has been implemented to document drills by shifts and quarters. -A quarterly drill schedule will be posted in the staff office assigning responsibility to each staff to conduct and document drills by dates. -the QP/house manager will verify that all drills are completed and documented on each date. -In absence of regular staff, the on call staff will be responsible for ensuring drills are conducted on designated shifts.	

			-The QP or House manager will review fie and disaster drill logs monthly to ensure each shift completes required drills. -Compliance will be reviewed each month with corrective action taken if any shift fails to comply. -QP will conduct quarterly audits to ensure continued adherence. Completion date: 7/30/2025	

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V 114	Continued From page 3 (d) Each facility shall have a first aid kit accessible for use. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure fire and disaster drills were completed quarterly and on each shift. The findings are: Review on 6/30/25 of the facility's fire and disaster drills from July 1, 2024 - June 29, 2025 revealed: - No 3rd shift fire or disaster drills Interview on 6/30/25 client #1 reported: - He had been at the facility since 4/11/25 - He had participated in fire and disaster drills - There had been no drills completed at night since he had been residing there Interview on 6/30/25 client #2 reported: - The facility practiced fire drills and tornado drills - He had never been woken up for a drill Interview on 6/30/25 client #3 reported: - He had practiced fire drills at the facility but not disaster drills - Staff #1 had told him what to do if there was a tornado - He would squat down and put his head down in the hallway if there was a tornado - Fire drills were only practiced during the day Interview on 6/30/25 staff #1 reported:	V 114		

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V 114	Continued From page 4 - He was responsible for fire and disaster drills - He completed a fire and disaster drill each month - "Haven't done one at night with them (clients). Mostly do them (drills) on first and second shifts" - "Mostly during the day. It's a tough neighborhood around here" - "I don't think anyone knows that I haven't done them at night. Is it required?" - "When they get their meds (medications), they're out sleeping, so I don't really bother them at night like that" Interview on 6/30/25 the Supervisor reported: - The shifts at the facility were" - First 8:00 am - 4:00 pm - Second 4:00 pm - 12:00 am - Third 12:00 am - 8:00 am - She was not aware that fire and disaster drills had not been completed on 3rd shift - Staff #1 should have completed 3rd shift drills This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 114		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are:	V 736		

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V 736	Continued From page 5 Observation on 6/30/25 at 11:50 am revealed: - The kitchen had the following: - The walls and cabinets were speckled with a brown substance - Window over the sink had a blind with one broken slat - The table felt sticky and had scratches across the entire surface - The bedroom of client #1 and client #5 had the following: - A strip of black tape about 18 inches long stuck to the carpet - Window with a blind with 3 broken slats - The bedroom for client #2 and client #4 had an area outside the bathroom with carpet with 2 rips about 12 inches each and an area about 12 inches long that was loose from the metal transition strip - The bedroom of client #3 had the following: - 2 strips of black tape stuck to the carpet by the door approximately 12 inches and 24 inches long - 2 spots covered with a black substance approximately the size of softballs inside the closet Interview on 6/30/25 staff #1 reported: - The black tape on the floor was because the carpet was ripped in those places Interview on 6/30/25 the Administrator reported: - She did not own the house the facility was in - She would reach out to the landlord about the repairs This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736	Corrective action: Facility& ground deficiencies -As of 7/30/2025 the cleanliness and safety issues are being addressed, including but not limited to : deep cleaning all living areas and bathrooms, etc. -Removal of cluttering, proper organization of all consumer and staff areas. -Repairs to (e.g. walls, flooring, broken fixtures, etc.) -A walk through inspection will be conducted by QP/ house manager to confirm corrections are in compliance. -A full facility inspection was conducted on 7/30/2025 to identify any additional maintenance or cleanliness issues. -Minor issues discovered will be scheduled to be resolved in a timely manner. -A facility maintance log has been implemented to track cleaning, maintenance issues and resolution timelines. -Staff are required to complete daily checklist to ensure all areas are clean and orderly throughout all shifts. -A weekly facility inspection should be completed by house manager, with findings documented. -During meetings staff should be refreshed on environmental safety standards. -Monthly designated staff will inspect the and findings will be reviewed with the staff for corrective action. - Noncompliance with cleanliness will be discussed with involved staff. Completion date 7/30/2025	