

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL098-077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/15/2018
--	---	---	---

NAME OF PROVIDER OR SUPPLIER THE WELLMAN CENTER 1	STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST GARNER STREET 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	<p>INITIAL COMMENTS</p> <p>An annual survey was completed on May 15, 2018. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.</p>	V 000		
V 114	<p>27G .0207 Emergency Plans and Supplies</p> <p>10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES</p> <p>(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.</p> <p>(b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.</p> <p>(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.</p> <p>(d) Each facility shall have basic first aid supplies accessible for use.</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure disaster drills were held quarterly and repeated on each shift. The findings are:</p> <p>Review on 05/15/18 of a facility staff list completed by the Qualified Professional (QP)/Director revealed:</p> <ul style="list-style-type: none"> - The facility has two 12 hour shifts. - 7am to 7pm. - 7pm to 7am. 	V 114		

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: MHL098-077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/15/2018
--	---	---	---

NAME OF PROVIDER OR SUPPLIER THE WELLMAN CENTER 1	STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST GARNER STREET 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 114	<p>Continued From page 1</p> <p>Review on 05/15/18 of facility records from 11/2018 thru 05/15/18 revealed the following documented disaster drills:</p> <ul style="list-style-type: none"> - 11/09/17 at 2:00pm. - 02/01/18 at 7pm. - 05/05/18 at 8am. <p>Interview on 05/15/18 client #8 stated he did not recall participation in a disaster drill at the facility.</p> <p>Interview on 05/15/18 staff #2 stated a disaster drill was completed quarterly.</p> <p>Interview on 05/15/18 the QP/Director stated:</p> <ul style="list-style-type: none"> - The facility had two 12 hour shifts from 7am to 7pm and 7pm to 7am. - He understood diaster drills were required to be completed quarterly and repeated on each shift. 	V 114		
V 736	<p>27G .0303(c) Facility and Grounds Maintenance</p> <p>10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on observations and interview, the licensee failed to maintain the facility in a safe and orderly manner. The findings are:</p> <p>Observation on 05/15/18 at approximately 10:50am revealed:</p> <ul style="list-style-type: none"> - The hallway bathroom revealed the tub drain 	V 736		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL098-077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/15/2018
--	---	---	---

NAME OF PROVIDER OR SUPPLIER THE WELLMAN CENTER 1	STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST GARNER STREET 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

V 736	<p>Continued From page 2</p> <p>was clogged and contained several inches of water.</p> <ul style="list-style-type: none"> - Client #1's bedroom revealed a small air conditioner unit in the only window available for egress. - Client #2 and client #3's bedroom revealed several broken drawers in a dresser. - Client #6 and client #7's bedroom revealed a small air conditioner unit in the only window available for egress. <p>Interview on 05/15/18 the Qualified Professional/Director stated:</p> <ul style="list-style-type: none"> - Someone had stolen the central air unit for the facility and air conditioners were placed in some client windows. - He understood the client's bedrooms needed to have an egress in the event of a fire. 	V 736		
-------	---	-------	--	--