Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			X3) DATE SURVEY COMPLETED	
			B. WING		R	
		mhl074-130	B. WING		12/0	5/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WECAR	E RESIDENTIAL FACI	LITY	SEVELT SP LLE, NC 278			
(X4) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
V 000	INITIAL COMMENT	rs	V 000			
		w-up survey was completed Deficiencies were cited.				
	category: 10A NCA	sed for the following service AC 27G .1700 Residential cure for Children and				
V 536	27E .0107 Client Ri Int.	ghts - Training on Alt to Rest.	V 536			
	practices that emph to restrictive interve (b) Prior to providir disabilities, staff incemployees, student demonstrate compe completing training other strategies for which the likelihood or injury to a persor property damage is (c) Provider agencibased on state common compliance and deligathered. (d) The training shall include measurable measurable testing behavior) on those methods to determicourse. (e) Formal refreshers	mplement policies and nasize the use of alternatives entions. In services to people with eluding service providers, as or volunteers, shall etence by successfully in communication skills and creating an environment in of imminent danger of abuse in with disabilities or others or				

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

(X6) DATE TITLE

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Division of Health Service Regulation							
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
			B. WING		R		
mhl074-130		B. WING		12/0	5/2018		
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
			DSEVELT SP				
WECARE	RESIDENTIAL FACI	ITY	_	_			
		GREENV	LLE, NC 278	834			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE DATE	
TAG	REGULATURY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIAIE	DATE	
V 536	Continued From pa	ge 1	V 536				
	•						
		raining that the service					
		employ must be approved by					
		DD/SAS pursuant to					
	Paragraph (g) of thi						
	(g) Staff shall demo	onstrate competence in the					
	following core areas	S:					
	(1) knowledge	e and understanding of the					
	people being serve	d;					
		ng and interpreting human					
	behavior;						
		ng the effect of internal and					
		hat may affect people with					
	disabilities;	nat may anost poople min					
	•	for building positive					
		ersons with disabilities;					
		ng cultural, environmental and					
		ors that may affect people with					
	disabilities;	is that may affect people with					
		a the importance of and					
		ng the importance of and					
		son's involvement in making					
	decisions about the						
		ssessing individual risk for					
	escalating behavior						
		cation strategies for defusing					
		ootentially dangerous behavior;					
	and	ala and a sala a sa					
		ehavioral supports (providing					
		vith disabilities to choose					
		ctly oppose or replace					
	behaviors which are	,					
	(h) Service provide						
		nitial and refresher training for					
	at least three years						
	(1) Documen	tation shall include:					
		ipated in the training and the					
	outcomes (pass/fail						
		where they attended; and					
	(C) instructor						
		ion of MH/DD/SAS may					
	(Z) THE DIVISI	เกม การเปลาการพราแเลง					

Division of Health Service Regulation

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Division	of Health Service Re	egulation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		mhl074-130	B. WING		12/0	₹ 5/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		1761 ROC	SEVELT SP	,		
WECARE RESIDENTIAL FACILITY		LLE, NC 27				
(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	(X5) COMPLETE DATE
V 536	Continued From pa	ge 2	V 536			
	(i) Instructor Qualif Requirements: (1) Trainers is by scoring 100% or aimed at preventing need for restrictive (2) Trainers is by scoring a passin instructor training p (3) The trainic competency-based objectives, measurable method failing the course. (4) The contest is service provider plate approved by the Disto Subparagraph (i) (5) Acceptable shall include but are (A) understan (B) methods course; (C) methods performance; and (D) document (6) Trainers is teaching a training reducing and elimin interventions at least review by the coach (7) Trainers is aimed at preventing need for restrictive annually. (8) Trainers is	shall demonstrate competence g grade on testing in an rogram. ng shall be , include measurable learning able testing (written and by avior) on those objectives and ds to determine passing or ent of the instructor training the ans to employ shall be vision of MH/DD/SAS pursuant (5) of this Rule. It instructor training programs e not limited to presentation of: ding the adult learner; for teaching content of the for evaluating trainee station procedures. Shall have coached experience program aimed at preventing, lating the need for restrictive est one time, with positive				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:		R	
		mhl074-130	B. WING			5/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WECAR	E RESIDENTIAL FACI	ITY	SEVELT SP LLE, NC 278	-		
(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	(X5) COMPLETE DATE
V 536	(j) Service provided documentation of ir training for at least (1) Docur (A) who particular outcomes (pass/fai (B) when and (C) instructor (2) The Divis request and review (k) Qualifications of (1) Coaches requirements as a form (2) Coaches the course which is (3) Coaches competence by contrain-the-trainer instruction of the course which is (3) Coaches competence by contrain-the-trainer instruction of the course which is (3) Coaches competence by contrain-the-trainer instruction of the course which is (3) Coaches competence by contrain-the-trainer instruction of the course which is (3) Coaches competence by contrain-the-trainer instruction of the course which is (3) Coaches competence by contrain-the-trainer instruction of the course which is (3) Coaches competence by contrain-the-trainer instruction of the course which is (3) Coaches competence by contrain-the-trainer instruction of the course which is (4) Coaches competence which is (4) Coaches competence which is (5) Coaches competence which is (6) Coaches competence which is (6) Coaches competence which is (7) Coaches competence which is (8) Coaches coaches competence which is (8) Coaches coaches coaches coach	rs shall maintain nitial and refresher instructor three years. mentation shall include: sipated in the training and the l); d where attended; and r's name. ion of MH/DD/SAS may this documentation any time. of Coaches: shall meet all preparation trainer. shall teach at least three times being coached. shall demonstrate npletion of coaching or	V 536			
	interviews, the facil audited staff (#3 an received annual tra	et as evidenced by: view, observation and ity failed to ensure two of five d Qualified Professional (QP)) ining updates in alternatives to ions. The findings are:				
	- Date of Application - Job Title: Associat Professional/Parap - North Carolina Int	te				

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	mhl074-130		B. WING R			₹ 5/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WECAR	RESIDENTIAL FACI	ITY	DSEVELT SP LLE, NC 278			
(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	(X5) COMPLETE DATE
V 536	Continued From pa	ge 4	V 536		-	
	restrictive interventi					
	Review on 12/05/18 of the QP's record revealed: - Date of application: 12/01/04 Job Title: QP - NCI training in alternatives to restrictive interventions expired effective 03/01/18 No current training updates in alternatives to restrictive interventions.					
	stated: - A NCI training had month He was aware all	18 the Operations manager been scheduled for staff this staff needed to have current e to restrictive interventions.				
V 537	27E .0108 Client Ri	ghts - Training in Sec Rest &	V 537			
	ISOLATION TIME-(a) Seclusion, physitime-out may be embeen trained and hacompetence in the to these procedures staff authorized to eprocedures are retricompetence at least (b) Prior to providing disabilities whose traincludes restrictive service providers, evolunteers shall contract the service providers of the service p	SICAL RESTRAINT AND DUT sical restraint and isolation aployed only by staff who have ave demonstrated proper use of and alternatives as. Facilities shall ensure that employ and terminate these ained and have demonstrated				

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Division of Health Service Regulation

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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		mhl074-130	J. WINO		12/0	5/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY. S	STATE, ZIP CODE		
			SEVELT SP			
WECARE	E RESIDENTIAL FACI	ITY	_	_		
		GREENVI	LLE, NC 27	034		I
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF		COMPLETE DATE
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				·		1
V 537	Continued From pa	ge 5	V 537			
	and aball not use th	and interventions until the				
		ese interventions until the				
		d and competence is				
	demonstrated.	fan kaldina klain kustistis si ts				
		for taking this training is				
		petence by completion of				
		g, reducing and eliminating				
	the need for restrict					
		ill be competency-based,				
		e learning objectives,				
		(written and by observation of				
	behavior) on those	objectives and measurable				
	methods to determi	ne passing or failing the				
	course.					
	(e) Formal refreshe	er training must be completed				
	by each service pro	vider periodically (minimum				
	annually).					
	(f) Content of the tr	raining that the service				
		nploy must be approved by				
		DD/SAS pursuant to				
	Paragraph (g) of thi					
		ning programs shall include,				
	but are not limited to	o. presentation of:				
		information on alternatives to				
	the use of restrictive					
		s on when to intervene				
		ninent danger to self and				
	others);	mont danger to sen and				
		on safety and respect for the				
		fall persons involved (using				
		estrictive interventions and				
	incremental steps in					
		for the safe implementation				
	(4) strategies of restrictive interve					
		f emergency safety				
	interventions which					
		onitoring of the physical and				
		being of the client and the safe				
		ughout the duration of the				
	restrictive interventi	on;				

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Division of Health Service Regulation

Division of Health Service Regulation							
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED	
					R		
		mhl074-130	B. WING		12/05/2018		
NAME OF I		PTDEET AS	DDEEC CITY (CTATE ZID CODE			
NAIVIE OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
WECAR	E RESIDENTIAL FACI	I ITY	DSEVELT SP				
		GREENV	ILLE, NC 27	834			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	`	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE	
17.0		,	1,710	DEFICIENCY)			
V 527	Continued From no	.a. 6	V 537				
V 537	Continued From pa	ge 6	V 557				
	(6) prohibited	I procedures;					
		strategies, including their					
	importance and pur	pose; and					
	(8) document	tation methods/procedures.					
	(h) Service provide	rs shall maintain					
	documentation of ir	nitial and refresher training for					
	at least three years						
	` '	tation shall include:					
		cipated in the training and the					
	outcomes (pass/fai						
		I where they attended; and					
	(C) instructor						
		ion of MH/DD/SAS may					
		documentation at any time.					
		ication and Training					
	Requirements:						
		shall demonstrate competence					
		n testing in a training program					
		g, reducing and eliminating the					
	need for restrictive						
		shall demonstrate competence testing in a training program					
		seclusion, physical restraint					
	and isolation time-o						
		shall demonstrate competence					
		g grade on testing in an					
	instructor training p						
		ng shall be					
		, include measurable learning					
		able testing (written and by					
		avior) on those objectives and					
	measurable method	ds to determine passing or					
	failing the course.						
		ent of the instructor training the					
	service provider pla	ns to employ shall be					
	approved by the Div	vision of MH/DD/SAS pursuant					
	to Subparagraph (j)	(6) of this Rule.					
	(6) Acceptab	le instructor training programs					
		ot be limited to, presentation					

Division of Health Service Regulation

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Division of Health Service Regulation

OTATEMENT OF DEFICIENCIES (AV.) PROVIDED/OLIDRI JED/OLIA						
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AIND LEVIN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R	
		mhl074-130	B. WING			5/2018
					1 12/00	3/2010
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WECAR	RESIDENTIAL FACI	I ITV	SEVELT SP			
WEOAK	LINEOIDENTIALIAOII	GREENVI	LLE, NC 27	334		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX	•	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE
				22.10.2.10		
V 537	Continued From pa	ge 7	V 537			
	of.					
	of:	ding the adult learner				
		ding the adult learner;				
	• •	for teaching content of the				
	course;	- of two:				
		n of trainee performance; and				
	` ,	ation procedures.				
	()	shall be retrained at least				
		nstrate competence in the use				
		al restraint and isolation				
		ed in Paragraph (a) of this				
	Rule.	من او و من مول الموا				
		shall be currently trained in				
	CPR.	وومونووريو لووطوووو ويروط الوطر				
		shall have coached experience				
		of restrictive interventions at				
	coach.	a positive review by the				
		shall tooch a program on the				
		shall teach a program on the erventions at least once				
	annually.	erverilloris at least office				
		hall complete a refresher				
		hall complete a refresher tleast every two years.				
	(k) Service provide					
		nitial and refresher instructor				
	training for at least					
	•	tation shall include:				
		ipated in the training and the				
	outcome (pass/fail)					
		, I where they attended; and				
	(C) instructor					
		ion of MH/DD/SAS may				
		documentation at any time.				
	(I) Qualifications of					
	()	shall meet all preparation				
	requirements as a t					
		shall teach at least three				
	` '	hich is being coached.				
		shall demonstrate				
	\ /	onletion of coaching or				

Division of Health Service Regulation

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	` '			LETED
			7 20.22		_	,
		mhl074-130	B. WING		12/0	5/2018
NAME OF			DDECC CITY (STATE ZID CODE	1 12/0	0/2010
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
WECARI	E RESIDENTIAL FACI	ITY	DSEVELT SP ILLE, NC 278	_		
0(1) ID	CLIMMA DV CTA					()(5)
(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 APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 537	Continued From pa	ge 8	V 537			
	train-the-trainer insi (m) Documentation preparation as for to	rruction. n shall be the same				
	facility failed to ensity (#3 and Qualified Pannual training updomestraint and isolation Review on 12/05/18 - Date of Application - Job Title: Associate Professional/Parap - North Carolina Intrupdates in seclusion isolation time-out expenses.	views and interviews, the ure two of five audited staff rofessional (QP)) received ates in seclusion, physical on time-out. The findings are 3 of staff #3's record revealed: n: 08/29/17				
	Physical restraint and Review on 12/05/18 - Date of application - Job Title: QP - NCI training update	nd isolation time-out. 3 of the QP's record revealed:				
	- No current training	g updates in seclusion, nd isolation time-out.				
	stated: - A NCI training had month He was aware all	18 the Operations manager I been scheduled for staff this staff needed to have current seclusion, physical restraint out.				

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PRINTED: 12/07/2018 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _____ R B. WING _ mhl074-130 12/05/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1761 ROOSEVELT SPAIN ROAD **WECARE RESIDENTIAL FACILITY** GREENVILLE, NC 27834 SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETE DATE (X4) ID PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY)

Division of Health Service Regulation