| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL098-077 | A. BUILDING: _____ B. WING _____ | 09/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE WELLMAN CENTER 1 | 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 | INITIAL COMMENTS<br><br>An annual survey was completed on September 23, 2021. Deficiencies were cited.<br><br>This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. | V 000 | | |
| V 114 | 27G .0207 Emergency Plans and Supplies<br><br>10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES<br>(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.<br>(b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.<br>(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.<br>(d) Each facility shall have basic first aid supplies accessible for use.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews the facility failed to have fire and disaster drills held at least quarterly and repeated on each shift. The findings are:<br><br>Review on 09/22/21 of facility record from August 2020 thru September 2021 revealed:<br>-Fire and disaster drill log book documented the shifts as 7a-3p 1st shift, 3p-11p 2nd shift and 11p-7a 3rd shift. | V 114 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL098-077 | A. BUILDING: _____ B. WING _____ | 09/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE WELLMAN CENTER 1 | 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 | Continued From page 1<br>- No fire drills documented for 3rd shift from August 2020 thru September 2021.<br>-No Fire drills documented for any shift in the months of October 2020-December 2020.<br>- No disaster drills documented for 3rd shift from August 2020 thru September 2021.<br>-January 2021-March 2021 only 1 disaster drill documented for 1st shift.<br>-April 2021-June 2021 only 1 disaster drill documented for 1st shift.<br>-July 2021-September 2021 no disaster drills documented.<br>-October 2020-December 2020 only 1 disaster drill documented for 2nd shift.<br><br>During interview on 09/22/21 clients #4, #5 and #8 revealed:<br>-They completed fire and disaster drills but did not know how often they were completed.<br><br>During interview on 09/23/21 the Licensed Practical Nurse revealed:<br>-The License could not be available for the exit due to not feeling well.<br>-She would give the Licensee the information about the fire and disaster drills. | V 114 | | |
| V 121 | 27G .0209 (F) Medication Requirements<br><br>10A NCAC 27G .0209 MEDICATION REQUIREMENTS<br>(f) Medication review:<br>(1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of | V 121 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL098-077 | A. BUILDING: _____ B. WING _____ | 09/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE WELLMAN CENTER 1 | 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 121 | Continued From page 2 | V 121 | | |

the review when medical intervention is indicated.
(2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable.

This Rule is not met as evidenced by:
Based on record reviews and interviews the facility failed to obtain drug regimen reviews for 3 of 3 audited clients (#4, #5 and #8) who received psychotropic drugs. The findings are:

Review on 9/22/21 of client #4's record revealed:
- 68 year old admitted 12/07/04.
- Diagnoses included Schizophrenia, paranoid type; Hypertension; Bronchial Asthma; and Prostate Cancer.
- Physician's order signed and dated 1/21/21 for Haldol (antipsychotic) 10 milligrams (mg) 1 tablet by mouth three times daily.
- Last drug regimen review dated August 2020.
- No current drug regimen review.

Review on 9/22/21 of client #5's record revealed:
- 62 year old admitted 6/01/05.
- Diagnoses included Schizophrenia, paranoid type; and Hypertension.
- Physician's orders signed and dated 1/21/21 for Haldol 10 mg 1 tablet by mouth at bedtime, and Trazodone (atypical antidepressant) 50 mg one tablet at bedtime.
- Last drug regimen review dated August 2020.
- No current drug regimen review.

Review on 9/22/21 of client #8's record revealed:
- 69 year old admitted 3/02/18.
- Diagnoses included Schizophrenia Disorder;

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL098-077 | A. BUILDING: _____ B. WING _____ | 09/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE WELLMAN CENTER 1 | 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 121 | Continued From page 3<br><br>Hypertension; and Hyponatremia.<br>- Physician's orders signed and dated 1/13/21 for Haldol 2 mg/milliliter (ml) take 1.25 ml by mouth every morning; Haldol 5 mg, 1 tablet by mouth at bedtime; and Haldol 100 mg/ml, inject 1 ml intramuscularly every 3 weeks.<br>- Last drug regimen review dated 5/18/20.<br>- No current drug regimen review.<br><br>The drug regimen reviews were requested several times during the survey from the Licensee and Office Manager and never provided.<br><br>During interview on 09/23/21 the Licensed Practical Nurse revealed:<br>-The License could not be available for the exit due to not feeling well.<br>-She would give the Licensee the information about the drug regimen reviews. | V 121 | | |
| V 536 | 27E .0107 Client Rights - Training on Alt to Rest. Int.<br><br>10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS<br>(a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions.<br>(b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented.<br>(c) Provider agencies shall establish training | V 536 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL098-077 | A. BUILDING: _____ B. WING _____ | 09/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE WELLMAN CENTER 1 | 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 536 | Continued From page 4<br>based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered.<br>(d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.<br>(e) Formal refresher training must be completed by each service provider periodically (minimum annually).<br>(f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.<br>(g) Staff shall demonstrate competence in the following core areas:<br>(1) knowledge and understanding of the people being served;<br>(2) recognizing and interpreting human behavior;<br>(3) recognizing the effect of internal and external stressors that may affect people with disabilities;<br>(4) strategies for building positive relationships with persons with disabilities;<br>(5) recognizing cultural, environmental and organizational factors that may affect people with disabilities;<br>(6) recognizing the importance of and assisting in the person's involvement in making decisions about their life;<br>(7) skills in assessing individual risk for escalating behavior;<br>(8) communication strategies for defusing and de-escalating potentially dangerous behavior; and<br>(9) positive behavioral supports (providing | V 536 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL098-077 | A. BUILDING: _____ B. WING _____ | 09/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE WELLMAN CENTER 1 | 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 536 | Continued From page 5<br>means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).<br>(h) Service providers shall maintain documentation of initial and refresher training for at least three years.<br>(1) Documentation shall include:<br>(A) who participated in the training and the outcomes (pass/fail);<br>(B) when and where they attended; and<br>(C) instructor's name;<br>(2) The Division of MH/DD/SAS may review/request this documentation at any time.<br>(i) Instructor Qualifications and Training Requirements:<br>(1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.<br>(2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.<br>(3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.<br>(4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule.<br>(5) Acceptable instructor training programs shall include but are not limited to presentation of:<br>(A) understanding the adult learner;<br>(B) methods for teaching content of the course;<br>(C) methods for evaluating trainee performance; and | V 536 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL098-077 | A. BUILDING: _____ B. WING _____ | 09/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE WELLMAN CENTER 1 | 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 536 | Continued From page 6<br>(D) documentation procedures.<br>(6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach.<br>(7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually.<br>(8) Trainers shall complete a refresher instructor training at least every two years.<br>(j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.<br>(1) Documentation shall include:<br>(A) who participated in the training and the outcomes (pass/fail);<br>(B) when and where attended; and<br>(C) instructor's name.<br>(2) The Division of MH/DD/SAS may request and review this documentation any time.<br>(k) Qualifications of Coaches:<br>(1) Coaches shall meet all preparation requirements as a trainer.<br>(2) Coaches shall teach at least three times the course which is being coached.<br>(3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.<br>(l) Documentation shall be the same preparation as for trainers. | V 536 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL098-077 | A. BUILDING: _____ B. WING _____ | 09/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE WELLMAN CENTER 1 | 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 536 | Continued From page 7<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews the facility failed to ensure 3 of 3 staff (#1, the Office Manager and the Licensee/Qualified Professional) received annual training updates in alternatives to restrictive interventions. The findings are:<br><br>Review on 9/22/21 of staff #1 record revealed:<br>- Hire date 7/02/07.<br>- Title of Direct Care Staff.<br>- No current training in alternatives to restrictive interventions.<br><br>Review on 9/22/21 of the Office Manager's record revealed:<br>- Hire date 7/01/07.<br>- No current training in alternatives to restrictive interventions.<br><br>Review on 9/22/21 of the Licensee/Qualified Professional's record revealed:<br>- Hire date 1/01/07.<br>- No current training in alternatives to restrictive interventions.<br><br>During interview on 9/22/21 the Licensee/Qualified Professional revealed:<br>-Some of the staff training "may be behind because the training lady won't come out because of the virus." | V 536 | | |
| V 736 | 27G .0303(c) Facility and Grounds Maintenance<br><br>10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS<br>(c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly | V 736 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL098-077 | A. BUILDING: _____ B. WING _____ | 09/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE WELLMAN CENTER 1 | 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 | Continued From page 8<br>manner and shall be kept free from offensive odor.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview the Licensee failed to maintain the facility in a safe, clean manner and free from offensive odors. The findings are:<br><br>Observation on 9/22/21 at approximately 11:00am of the facility revealed:<br>- Sour odor throughout the facility.<br>- The carpet throughout the facility was heavily stained.<br>- Ceilings throughout the facility sagged and had brown stains consistent with water damage.<br>-A smoke detector was beeping approximately every 60 seconds.<br>-Client #7 and #8's bedroom the wall was damaged and the headboard of the bed was worn and discolored.<br>-The facility as a whole appeared unkept, dirty and dingy.<br><br>During interview on 9/22/21 the Licensee/Qualified Professional stated:<br>-He was aware the facility needed updates.<br>-The maintenance person he had used for years had moved to another state. | V 736 | | |