Division	of Health Service Regu	ılation			ION	M APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL098-077	B. WING		00/	22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE	09/	23/2021
THE WEL	LMAN CENTER 1		ST GARNER ST			
			N, NC 27893			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS		V 000			
	An annual survey was 23, 2021. Deficiencie	completed on September s were cited.				
	category: 10A NCAC	I for the following service 27G .5600A Supervised Mental Illness.				
	Living for Adults with Mental Illness. 27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (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. (b) The plan 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 fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record reviews and interviews the		1	Five Deills are conducted ever munths on rotating shifts. These deills are unanswere Disacter Deills are done quartly on each of the two shifts. A calendar of scheduled five and disacter deills will be ke by the office manager. The Facility operates on two twelve how shifts, from The to 7pm and 7pm to 7 pm there is no third shift		
1 1 2 -	least quarterly and repe findings are: Review on 09/22/21 of 2020 thru September 2	og book documented the		RECEIVED OCT 1 5 2021 DHSR-MH Licensure Sec		

STATE FORM

If continuation sheet 1 of 9

PRINTED: 09/29/2021 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: _ MHL098-077 09/23/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST GARNER STREET THE WELLMAN CENTER 1 WILSON, NC 27893 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PRFFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 114 | Continued From page 1 V 114 - No fire drills documented for 3rd shift from August 2020 thru September 2021. -No Fire drills documented for any shift in the months of October 2020-December 2020. - No disaster drills documented for 3rd shift from August 2020 thru September 2021. -January 2021-March 2021 only 1 disaster drill documented for 1st shift. The Divertor has long haul could symptoms including headaches, fatigue and shortness of byrath No disvespect was intended. The Nurseand Board of Divertor members, has many years of expense at the Focility. No disvespect was intended was intended was intended. -April 2021-June 2021 only 1 disaster drill documented for 1st shift. -July 2021-September 2021 no disaster drills documented. -October 2020-December 2020 only 1 disaster drill documented for 2nd shift. During interview on 09/22/21 clients #4, #5 and #8 revealed: -They completed fire and disaster drills but did not know how often they were completed. During interview on 09/23/21 the Licensed Practical Nurse revealed: -The License could not be available for the exit due to not feeling well. -She would give the Licensee the information about the fire and disaster drills V 121 27G .0209 (F) Medication Requirements V 121 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review:

Division of Health Service Regulation

(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

STATE FORM

<u>Division of Health Service Regulation</u>							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL098-077	B. WNG		09	/23/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET	DDRESS, CITY, S	TATE, ZIP CODE			
THE WELLMAN CENTER 1 410 WES			ST GARNER ST , NC 27893	REET			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICE OF THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO) BE	(X5) COMPLETE DATE	
V 121	the review when med (2) The findings of the be recorded in the clie corrective action, if ap	ical intervention is indicated. e drug regimen review shall ent record along with oplicable. as evidenced by:	V 121	Drug verieus are dun	e by	nd la	
	of 3 audited clients (#4 psychotropic drugs. T Review on 9/22/21 of 6 68 year old admitted - Diagnoses included 5 type; Hypertension; Br Prostate Cancer Physician's order sig Haldol (antipsychotic) by mouth three times of Last drug regimen re - No current drug regimen	drug regimen reviews for 3 4, #5 and #8) who received the findings are: client #4's record revealed: 12/07/04. Schizophrenia, paranoid conchial Asthma; and med and dated 1/21/21 for 10 milligrams (mg) 1 tablet daily. view dated August 2020. men review.		Drug reviews are done the pharmist and the OM a quarely base Address this issue to office manager will all drug reviews in record books as a sthey are complete	Divedus. To he File Client	LUIJ	
	- 62 year old admitted - Diagnoses included S type; and Hypertensior - Physician's orders sig Haldol 10 mg 1 tablet t Trazodone (atypical an tablet at bedtime Last drug regimen rev - No current drug regim Review on 9/22/21 of c - 69 year old admitted S	Schizophrenia, paranoid n. gned and dated 1/21/21 for by mouth at bedtime, and tidepressant) 50 mg one view dated August 2020. hen review.				•	

PRINTED: 09/29/2021 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: _ B. WING MHL098-077 09/23/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **410 WEST GARNER STREET** THE WELLMAN CENTER 1 WILSON, NC 27893 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 121 Continued From page 3 V 121 Hypertension; and Hyponatremia. - 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. Last drug regimen review dated 5/18/20. - No current drug regimen review. The drug regimen reviews were requested several times during the survey from the Licensee and Office Manager and never provided. During interview on 09/23/21 the Licensed Practical Nurse revealed: -The License could not be available for the exit due to not feeling well. -She would give the Licensee the information about the drug regimen reviews. V 536 27E .0107 Client Rights - Training on Alt to Rest. V 536 Int 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives

Division of Health Service Regulation

to restrictive interventions.

property damage is prevented.

(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

(c) Provider agencies shall establish training

STATE FORM

PRINTED: 09/29/2021 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: B. WING MHL098-077 09/23/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **410 WEST GARNER STREET** THE WELLMAN CENTER 1 **WILSON, NC 27893** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) V 536 V 536 Continued From page 4 based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (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. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (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. (g) Staff shall demonstrate competence in the following core areas: knowledge and understanding of the (1) people being served; (2)recognizing and interpreting human behavior; (3)recognizing the effect of internal and external stressors that may affect people with disabilities: (4)strategies for building positive relationships with persons with disabilities: (5)recognizing cultural, environmental and organizational factors that may affect people with disabilities:

and (9)

(6)

(7)

decisions about their life;

escalating behavior;

recognizing the importance of and assisting in the person's involvement in making

skills in assessing individual risk for

communication strategies for defusing and de-escalating potentially dangerous behavior:

positive behavioral supports (providing

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Division	of Health Service Regu	ulation			FOR	RM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL098-077	B. WING		09	/23/2021
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V 536	Continued From page	e 5	V 536			
	means for people with activities which directly behaviors which are u (h) Service providers documentation of initia at least three years. (1) Documentation of initia at least three years. (1) Documentation of initia at least three years. (1) Documentation of pass/fail); (B) Whon participation outcomes (pass/fail); (B) When and Who (C) instructor's moderate of the provision review/request this document of the provision review/request this document of the provision of the pr	th disabilities to choose ally oppose or replace cursafe). It is shall maintain all and refresher training for attion shall include: atted in the training and the where they attended; and name; in of MH/DD/SAS may ocumentation at any time. Attions and Training all demonstrate competence asting in a training program reducing and eliminating the derventions. All demonstrate competence grade on testing in an oram, ashall be colude measurable learning are testing (written and by or) on those objectives and to determine passing or of the instructor training the to employ shall be on of MH/DD/SAS pursuant				

performance; and

PRINTED: 09/29/2021 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: ___ B. WING MHL098-077 09/23/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST GARNER STREET THE WELLMAN CENTER 1 **WILSON, NC 27893** SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) V 536 Continued From page 6 V 536 (D) documentation procedures. (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. Trainers shall teach a training program (7)aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. Trainers shall complete a refresher (8) instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. Documentation shall include: (1) (A) who participated in the training and the

Division of Health Service Regulation

outcomes (pass/fail):

when and where attended; and

The Division of MH/DD/SAS may request and review this documentation any time.

Coaches shall meet all preparation

Coaches shall demonstrate competence by completion of coaching or

(I) Documentation shall be the same preparation

Coaches shall teach at least three times

instructor's name.

(k) Qualifications of Coaches:

the course which is being coached.

requirements as a trainer.

train-the-trainer instruction.

as for trainers.

(B)

(C)

(2)

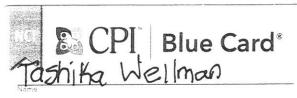
(1)

(2)

(3)

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: B. WING MHL098-077 09/23/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST GARNER STREET THE WELLMAN CENTER 1 **WILSON, NC 27893** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 536 Continued From page 7 V 536 This Rule is not met as evidenced by: 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: Review on 9/22/21 of staff #1 record revealed: - Hire date 7/02/07. - Title of Direct Care Staff. - No current training in alternatives to restrictive interventions. Review on 9/22/21 of the Office Manager's record revealed: Hire date 7/01/07. - No current training in alternatives to restrictive interventions Review on 9/22/21 of the Licensee/Qualified Professional's record revealed: - Hire date 1/01/07. - No current training in alternatives to restrictive interventions. During interview on 9/22/21 the Licensee/Qualified Professional revealed: -Some of the staff training "may be behind because the training lady won't come out because of the virus." V 736 27G .0303(c) Facility and Grounds Maintenance V 736 10A NCAC 27G .0303 LOCATION AND **EXTERIOR REQUIREMENTS** (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL098-077	B. WNG		09/	/23/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
THE WEL	LMAN CENTER 1	410 WES	T GARNER ST	REET		
		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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 736	Continued From page	8	V 736			
	manner and shall be k odor.	cept free from offensive		A house deeper and	a	
	failed to maintain the fimanner and free from findings are: Observation on 9/22/2 11:00am of the facility - Sour odor throughout - The carpet throughout the brown stains consistent - A smoke detector was every 60 seconds Client #7 and #8's bed damaged and the head and discolored The facility as a whole and dingy. During interview on 9/2 Licensee/Qualified Pro- He was aware the facil	and interview the Licensee acility in a safe, clean offensive odors. The 1 at approximately revealed: the facility. It the facility was heavily the facility sagged and had at with water damage. Seeping approximately droom the wall was aboard of the bed was worn appeared unkept, dirty 12/21 the fessional stated: Itity needed updates. Soon he had used for years		A housekeeper and New handy wan has hired to clean all thomes, carpets, walls painting walls and Ceilings	been for and	



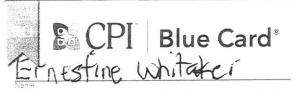
has completed the CPI Nonviolent Crisis Intervention®

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For more learning opportunities visit crisisprevention.com.

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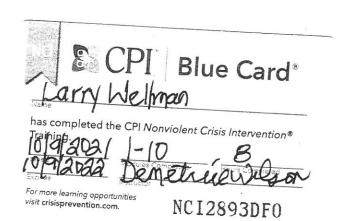


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ECPI Blue Carde letyn Gonez has completed the CPI Nonviolent Crisis Intervention®

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NCI2893E52

has successfully completed and competently performed the required knowledge and skill objectives for this program. Adult and Child Adult, Child, and Infant Card is valid if more than one bax is checked.

[] Adult

☐ Adult and Child







This card certifies the above named individual has successfully completed the required objectives and hands-on skill evaluations to the satisfaction of a currently authorized ASHI instructor. This program conforms to the 2015 AHA Guidelines Update for CPR and ECC and the 2015 AHA and ARG Guidelines Update for First Aid. This program is not designed to meet pediatric first aid training regulatory requirements and should not be used for that purpose. Expiration date may not exceed two years from month of class completion.

hS1 Health & Safety

has successfully completed and competently performed the required knowledge and skill objectives for this program. Adult and Child Adult, Child, and Infant Cent is void if more than one box is checked. ☐ Adult and Child [] Adult

AMERICAN SAFETYA HEALTH SI INSTITUTE

This card certifies the above named individual has successfully completed the required objectives and hands-on skill evaluations to the satisfaction of a currently authorized ASH Instructor. This program conforms to the 2015 AHA Guidelines Update for CPR and ECC and the 2015 AHA and program conforms to the 2015 AHA Guidelines Update for CPR and ECC and the 2015 AHA and PRO Guidelines Update for First AH. This program is not designed to meet pediatric first aid training regulatory requirements and should not be used for that purpose. Expiration date may not exceed two years from month of class completion.





AMERICAN III SAFETYA HEALTHIIII INSTITUTE

This card certifies the above named individual has successfully completed the required objectives and hands-on skill evaluations to the satisfaction of a currently authorized ASHI instructor. This program conforms to the 2015 AHA Guidelines Update for CPR and ECC and the 2015 AHA and ARC Guidelines Update for First AVI. This program is not designed to meet pediatric first aid training regulatory requirements and should not be used for that purpose. Expiration date may not exceed two years from month of class completion.

has successfully completed and competently performed the required knowledge and skill objectives for this program.

Adult and Child Adult, Child, and Infant

☐ Adult

Card is valid if more than one box is checked.



AMERICAN SAFETY& HEALTH IN INSTITUTE

Training Center Phone No.

Training Center I.D.

This card certifies the above named individual has successfully completed the required objectives and hands-on skill evaluations to the satisfaction of a currently authorized ASHI Instructor. This program conforms to the 2015 AHA Guidelines Update for CPR and ECC and the 2015 AHA and ARC Guidelines Update for First Ald. This program is not designed to meet pediatric first aid training regulatory requirements and should not be used for that purpose. Expiration date may not exceed two years from month of class completion.