Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE COMP	SURVEY LETED
		MHL026-978	B. WING		04/2	0/2022
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S DGER STRE	STATE, ZIP CODE		
EXCEL C	CARE AGENCY INCOM	RPORATED	ETTEVILLE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	rs	V 000			
An annual survey was completed on April 20, 2022. Deficiencies were cited.						
	category: 10A NCA Living for Adults wit					
		sed for 6 and currently has a urvey sample consisted of clients.				
V 112	27G .0205 (C-D) Assessment/Treatr	nent/Habilitation Plan	V 112			
	10A NCAC 27G .02 TREATMENT/HAB PLAN (c) The plan shall be assessment, and in legally responsible of admission for clireceive services be (d) The plan shall in (1) client outcome (achieved by provisi projected date of acceptance) as the projected date of acceptance (2) strategies; (3) staff responsible (4) a schedule for annually in consultar responsible person (5) basis for evaluation outcome achievem (6) written consent responsible party, or	205 ASSESSMENT AND ILITATION OR SERVICE  the developed based on the partnership with the client or person or both, within 30 days ents who are expected to syond 30 days. Include: (a) that are anticipated to be con of the service and a chievement;  the; It is a chieve to be plan at least atton with the client or legally or both; It is a chieve to a chieve to be plan at least atton or assessment of				

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

(X6) DATE TITLE

	Of Fleatill Service IN		1			
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:		COMP	LLILD
		MHL026-978	B. WING		04/2	0/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		1903 BRI	DGER STRE	FT .		
EXCEL (	CARE AGENCY INCOF	RPORATED	YETTEVILLE			
	OUR MAA DV OTA				O.U.	
(X4) ID PREFIX	=	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	<b>`</b>	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
V 112	Continued From pa	go 1	V 112			
V 112	Continued From pa	ge i	V 112			
	This Rule is not me	et as evidenced by:				
		view and interview the facility				
		atment plans were at least				
		signed written consent and				
		id implement goals and				
		ss client needs for three of				
		s (#1, #2 and #3). The findings				
	are:	5 (# 1, #2 and #6). The infamge				
	aro.					
	Finding #1:					
		2 of client #1's record				
	revealed:					
	- 69 year old male.					
	- Admission date of	· 08/27/21				
		derline Personality Disorder,				
		ood Disorder, Hypertension,				
		d Generalized Anxiety.				
		21 - Incontinent of Bladder.				
	1 L 2 dated 12/00/	21 moontment of Bladder.				
	Review on 04/20/23	of client #1's Person				
		CP) dated 04/08/21.				
	- No signed consen					
		ddress client #1's incontinence				
	of bladder.					
		completed in April 2022.				
	- INO allitual leview	completed in April 2022.				
	Finding #2:					
		2 of client #2's record				
	revealed:	2 Of Cliefft #2 5 fection				
		2				
	- 65 year old female					
	- Admission date 08					
		eralized Anxiety Disorder,				
	∣ Mood Disorder, Boi	rderline Personality Disorder,				

Division of Health Service Regulation

STATE FORM 6899 ETSF11 If continuation sheet 2 of 17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL026-9	978	B. WING		04/	20/2022
	PROVIDER OR SUPPLIER	RPORATED	1903 BRII	DRESS, CITY, S DGER STREI /ETTEVILLE			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 112	Bipolar Disorder, Al Hypertension.  Review on 04/20/22 04/10/21 revealed: - No annual review  Finding #3: Review on 04/20/22 revealed: - 60 year old male Admission date of - Diagnoses of Sch Reflux Disease, An Pulmonary Disease  Review on 04/20/22 Centered-Profile (P - No signed consentation of the con	lergic Rhinitis and lergic Rhinitis and lergic Rhinitis Rhinitis and lergic Rhinitis and lergic Rhinitis Rhi	PCP dated pril 2022. ecord stroesophageal nic Obstructive Person 0/21. pril 2022. I Professional need to be ne client or der at times. needed to	V 112			
V 114	27G .0207 Emerge 10A NCAC 27G .02 AND SUPPLIES (a) A written fire pla area-wide disaster shall be approved be authority. (b) The plan shall be	07 EMERGENO n for each facili plan shall be de by the appropria	CY PLANS ity and eveloped and ite local	V 114			

Division of Health Service Regulation

STATE FORM 6899 ETSF11 If continuation sheet 3 of 17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL026	-978	B. WING		04/2	20/2022
	PROVIDER OR SUPPLIER	RPORATED	1903 BRII	DRESS, CITY, S DGER STREI 'ETTEVILLE			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
V 114	Continued From parand evacuation proposted in the facility (c) Fire and disaste shall be held at least repeated for each sunder conditions the (d) Each facility shall accessible for use.  This Rule is not me Based on record refailed to have fire a quarterly and repeatance:	cedures and ro  r drills in a 24- st quarterly and hift. Drills shal at simulate fire all have basic f  et as evidence view and inter nd disaster dri	hour facility d shall be I be conducted e emergencies. irst aid supplies d by: view the facility lls held at least	V 114			
	Review on 04/20/22 October 2021 thru I - No documented fi quarter of 2021 No disaster drills of 2022. Interview on 04/20/2 (QP) stated: - She and staff #1 v - She was unable to drills for 2021 She understood fi required to be compleach shift.	March 2022 re re or disaster of documented for 22 the Qualifie worked at the for locate the fire re and disaste	vealed: drills for the 4th or the 1st quarter d Professional acility. e and disaster or drills were				
V 118	27G .0209 (C) Med 10A NCAC 27G .02 REQUIREMENTS (c) Medication adm	:09 MEDICATI		V 118			

Division of Health Service Regulation

STATE FORM 6899 ETSF11 If continuation sheet 4 of 17

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
711012711	or contraction	IBERTII TOXITOR	TTOMBET.	A. BUILDING:	<del></del>	001111	
		MHL026-978	1	B. WING		04/2	20/2022
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EXCEL (	CARE AGENCY INCO	RPORATED		DGER STRE			
	I			ETTEVILLE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIEN Y MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
V 118	Continued From pa	ige 4		V 118			
V 110	(1) Prescription or ronly be administered order of a person adrugs. (2) Medications shaclients only when a client's physician. (3) Medications, incadministered only bunlicensed persons pharmacist or othe privileged to prepare (4) A Medication Adall drugs administe current. Medication recorded immediat MAR is to include to (A) client's name; (B) name, strength (C) instructions for (D) date and time to (E) name or initials drug. (5) Client requests checks shall be recofile followed up by a with a physician.	non-prescription died to a client on the uthorized by law to all be self-administ uthorized in writing cluding injections, so licensed person a trained by a regist regally qualified person administration Record to each client it is administered shely after administration the following:  , and quantity of the administering the drug is administering the he drug is administering the drug is admi	e written o prescribe ered by g by the shall be s, or by stered nurse, person and medications. rd (MAR) of must be kept all be ation. The e drug; drug; tered; and stering the anges or th the MAR nsultation				
	This Rule is not me Based on record re facility failed to kee two of three audited findings are:	views and intervie p the MARs curre	ws, the nt affecting				

Division of Health Service Regulation

STATE FORM 6899 ETSF11 If continuation sheet 5 of 17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL026	6-978	B. WING		04/2	0/2022
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
EXCEL (	CARE AGENCY INCO	RPORATED		OGER STRE			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 118	Continued From particles of the particle	2 of client #2's e. 8/27/21. heralized Anxierderline Perso llergic Rhinitis 2 of client #2's revealed: eats Hypothyro take once dail iety) 1 milligra  Hypertension  voluntary mus nes daily. 2 of client #2's Rs revealed: 0mcg - transcr //22 thru 04/19 f initials to indit 04/01/22 thru	ety Disorder, anality Disorder, and signed sidism) 112 ly.  Ims (mg) - take scle movements)  March 2022  Tibed as 0/22.  Tibed as 0/22.  Ticate 1 04/03/22.	V 118			
	- Ativan - No staff in administration on 0 - Metoprolol - No staff	3/04/22 and 0	3/05/22 at 2pm.				

Division of Health Service Regulation

STATE FORM 6899 ETSF11 If continuation sheet 6 of 17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		MHL020	6-978	B. WING		04/2	20/2022
	PROVIDER OR SUPPLIER	RPORATED	1903 BRII	DRESS, CITY, S DGER STRE 'ETTEVILLE			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUNDERSON THE APPROPRIES OF	JLD BE	(X5) COMPLETE DATE
V 118	Continued From paradministration twice 03/03/22.  Interview on 04/20/22 received her medic Finding #2: Review on 04/20/22 revealed: - 60 year old male Admission date of - Diagnoses of Sch Reflux Disease, An Pulmonary Disease Review on 04/20/22 physician orders daren administer one drop Review 04/20/22 of March 2022 and Approximate for the following transcribe - Alphagan 0.1% - a eye once daily Staff initials to indiadministered once Interview on 04/20/20/21 stated: - All clients received by the physician Staff may have for administering medical rescribed entries.	e daily on 03/6 22 client #2 stations daily at 2 of client #3's 108/27/21. Izophrenia, Goxiety and Chrob. 2 of client #3's red 12/09/21 by pressure) of in each eye administer on a client #3's Febril 2022 MAR dentry: administer on a client the Alph daily. 22 the Qualified their medical regotten to initications. It the pharmace	tated she s ordered.  s record  astroesophageal onic Obstructive  s signed revealed: 0.1% - twice daily.  ebruary 2022, s revealed the e drop in each agan was  ed Professional ations as ordered al MARs after	V 118			
V 536	27E .0107 Client Ri Int.	ghts - Trainin	g on Alt to Rest.	V 536			

Division of Health Service Regulation

STATE FORM 6899 ETSF11 If continuation sheet 7 of 17

	NT OF DEFICIENCIES OF CORRECTION		R/SUPPLIER/CLIA ATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL02	6-978	B. WING		04/	20/2022	
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE			
EXCEL (	CARE AGENCY INCOM	RPORATED		DGER STREI ÆTTEVILLE				
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
V 536	Continued From pa	ge 7		V 536				
	people being serve	mplement ponasize the use entions. In g services to eluding services to eluding services to roluntee etence by such in communic creating an eluding an eluding services shall estal prevented. It is shall estal prevented elearning objectives and ine passing of er training municular periodic raining that the polysas purs is Rule. In the polysas purs is Rule and unders	licies and e of alternatives  people with e providers, ers, shall excessfully ation skills and environment in danger of abuse ties or others or blish training conitor for internal ey acted on data ency-based, ectives, by observation of d measurable r failing the est be completed cally (minimum es service be approved by uant to  petence in the tanding of the					

Division of Health Service Regulation

STATE FORM 6899 ETSF11 If continuation sheet 8 of 17

Division of Fleatin Service Regulation					ı	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		MHL026-978	B. WING		04/2	0/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		1903 BRII	OGER STRE			
EXCEL C	CARE AGENCY INCOM	PROPATED	ETTEVILLE			
0(4) ID	CUMMA DV CTA	TEMENT OF DEFICIENCIES			NI	()(5)
(X4) ID PREFIX	_	/ MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP		DATE
				DEFICIENCY)		
V 536	Continued From pa	ige 8	V 536			
	(2) recognizin	as the offeet of internal and				
		ng the effect of internal and hat may affect people with				
	disabilities;	nat may anect people with				
	I	for building positive				
		ersons with disabilities;				
		ng cultural, environmental and				
		ors that may affect people with				
	disabilities;	no macmay amost poopto man				
		ng the importance of and				
		son's involvement in making				
	decisions about the					
	(7) skills in as	ssessing individual risk for				
	escalating behavior	·· ,				
	(8) communic	cation strategies for defusing				
	and de-escalating p	ootentially dangerous behavior;				
	and					
		ehavioral supports (providing				
		vith disabilities to choose				
		ectly oppose or replace				
	behaviors which are					
	(h) Service provide					
		nitial and refresher training for				
	at least three years	tation shall include:				
	· ,	cipated in the training and the				
	outcomes (pass/fail					
		d where they attended; and				
	(C) instructor					
		ion of MH/DD/SAS may				
		documentation at any time.				
	(i) Instructor Qualifications and Training					
	Requirements:					
	(1) Trainers shall demonstrate competence					
		n testing in a training program				
		g, reducing and eliminating the				
	need for restrictive					
		shall demonstrate competence				
		g grade on testing in an				
	instructor training p					

Division of Health Service Regulation

STATE FORM 6899 ETSF11 If continuation sheet 9 of 17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED		
		MHL026	-978	B. WING		04/	20/2022
	PROVIDER OR SUPPLIER	RPORATED	1903 BRII	DRESS, CITY, S DGER STREI 'ETTEVILLE			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 536	(3) The trainic competency-based objectives, measurable method failing the course. (4) The conteservice provider plate approved by the Divito Subparagraph (i) (5) Acceptable shall include but are (A) understand (B) methods course; (C) methods performance; and (D) document (6) Trainers steaching a training reducing and eliming interventions at least review by the coach (7) Trainers steaching at preventing need for restrictive annually. (8) Trainers steaching and eliming interventions at least review by the coach (7) Trainers steaching at preventing need for restrictive annually. (8) Trainers steaching and eliming need for restrictive annually. (1) Service provided documentation of intraining for at least (1) Document (1) Document (2) Who particulation of intraining for at least (1) methods (1) who particulation of intraining for at least (1) methods (1) who particulation of intraining for at least (1) methods (1) meth	ng shall be include mease able testing (wavior) on those dis to determinate to distribute the instructor trace and limited to ding the adult for teaching conformation procedure that have coach program aiments at one time, with the instructor trace and limited to ding the adult for teaching conformation procedure that have coach program aiments at one time, with the instructors are shall teach a trace, reducing and interventions are shall completed the state of the instruction of the total limital and refrest three years.  The instructor trace are the instruction of the total limital and refrest three years.  The instructor trace is not limital and refrest three years.  The instructor trace is not limital and refrest three years.  The instructor trace is not limital and refrest three years.  The instructor trace is not limited in the trace is not limital and refrest three years.  The instructor trace is not limited to the instructor in the trace is not limited in the t	ritten and by objectives and e passing or uctor training the shall be iD/SAS pursuant e. aining programs opresentation of: learner; ontent of the trainee res. It ched experience dat preventing, if for restrictive the positive aining program deliminating the at least once a refresher wo years. In when instructor I include: raining and the ed; and SAS may	V 536			

Division of Health Service Regulation

STATE FORM 6899 ETSF11 If continuation sheet 10 of 17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL026	i-978	B. WING		04/	20/2022
	PROVIDER OR SUPPLIER	RPORATED	1903 BRII	DRESS, CITY, S DGER STREI ETTEVILLE			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 536	(k) Qualifications of (1) Coaches requirements as a to (2) Coaches the course which is	f Coaches: shall meet all rainer. shall teach at being coache shall demonst npletion of coa	least three times ed. crate aching or	V 536			
	This Rule is not me Based on record re failed to ensure one Professional (QP)) updates in alternation The findings are:  Review on 04/20/22 revealed:  - Date of hire: 04/2′  - National Crisis Intupdates in alternative expired effective Material expired effective Material expired effective intervention of the professional current training restrictive intervention of the professional expired effective intervention of the professional expired effective intervention of the professional expired effective intervention of the professional effective intervention in the professional effective intervention of the professional effective intervention in the profession in the professional effective intervention in the profession	view and interes of two staff (creceived annuves to restriction of the QP's particularly of the QP's particularly of the QP staff were relates in alternations.	view, the facility Qualified all training ve interventions.  Dersonnel record as (NCI+) training ve interventions alternatives to ted: Equired to have atives to raining in				

Division of Health Service Regulation

STATE FORM 6899 ETSF11 If continuation sheet 11 of 17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED		
MHL026-978		3	B. WING		04/	20/2022	
	PROVIDER OR SUPPLIER	RPORATED	1903 BRII	DRESS, CITY, S DGER STRE CETTEVILLE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 537	27E .0108 Client Ri ITO  10A NCAC 27E .01 SECLUSION, PHYSISOLATION TIME-0 (a) Seclusion, physitime-out may be en been trained and had competence in the to these procedures staff authorized to e procedures are retrestaff authorized to expression providers, evolunteers shall consecution, physical and shall not use the training is completed demonstrated.  (c) A pre-requisited demonstrating completed demonstrating completed demonstration proventing the need for restrict (d) The training shall include measurable measurable testing behavior) on those methods to determine course.  (e) Formal refreshed by each service provider plans to enthe Division of MH// Paragraph (g) of the provider plans to enthe Division of MH// Paragraph (g) of the provider plans to enthe Division of MH// Paragraph (g) of the provider plans to enthe Division of MH// Paragraph (g) of the provider plans to enthe Division of MH// Paragraph (g) of the provider plans to enthe Division of MH// Paragraph (g) of the provider plans to enthe Division of MH// Paragraph (g) of the provider plans to enthe Division of MH// Paragraph (g) of the provider plans to enthe Division of MH// Paragraph (g) of the provider plans to enthe Division of MH// Paragraph (g) of the provider plans to enthe Division of MH// Paragraph (g) of the provider plans to enthe Division of MH// Paragraph (g) of the provider plans to enthe Division of MH// Paragraph (g) of the provider plans to enthe Division of MH// Paragraph (g) of the provider plans to enthe Division of MH// Paragraph (g) of the provider plans to enthe Division of MH// Paragraph (g) of the provider plans to enthe Division of MH// Paragraph (g) of the provider plans to enthe Division of MH// Paragraph (g) of the provider plans to enthe Division plans to enthe Division plans to enthe Division plans to enthe Divisi	O8 TRAINING SICAL RESTRAIN OUT sical restraint and apployed only by sta ave demonstrated proper use of and s. Facilities shall e employ and termin ained and have de st annually. g direct care to pe reatment/habilitation interventions, staf employees, studen mplete training in ta restraint and isolate interventions and competence for taking this train petence by complete interventions. all be competency to and the se mploy must be proposed to a populate the proposed to a populate to an and the se mploy must be app DD/SAS pursuant	isolation aff who have alternatives ensure that ate these emonstrated eople with on plan fincluding ats or the use of ation time-out until the e is a hing is etion of eliminating especially based, es, oservation of easurable ang the ecompleted (minimum ervice proved by	V 537			

Division of Health Service Regulation

STATE FORM 6899 ETSF11 If continuation sheet 12 of 17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
THE PERIOD CONTROL				A. BUILDING:				
MHL026-978		B. WING		04/2	20/2022			
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
EXCEL (	CARE AGENCY INCOM	RPORATED		DGER STRE				
LXOLL	SAILE AGENOT INGGI	W ORATED	EAST FA	ETTEVILLE	, NC 28301			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE COMPLETE HE APPROPRIATE DATE		
V 537	Continued From pa	ige 12		V 537				
v 337	(g) Acceptable trai but are not limited to (1) refresher the use of restrictive (2) guidelines (understanding immothers); (3) emphasis rights and dignity of concepts of least reincremental steps in (4) strategies of restrictive interversions which assessment and many psychological well-luse of restrictive intervent (6) prohibited (7) debriefing importance and pur (8) document (6) prohibited (7) debriefing importance and pur (8) document (9) Service provided documentation of in at least three years (1) Document (A) who particulate outcomes (pass/fai (B) when and (C) instructor (2) The Divis review/request this (i) Instructor Qualif Requirements:	ning programs shate, presentation of: information on alter interventions; son when to intervention the intervention of all persons involved in an intervention; for the safe implementations; for the safe implementation of the physical persons include continuous onitoring of the client and intervention; for the safe implementation of the physical procedures; gestrategies, including the shall maintain intial and refresher that it is and the training of the physical procedures; and the training of the physical procedures and the physical procedures are the phy	ernatives to ene elf and pect for the ed (using ons and mentation / s ysical and and the safe on of the edures. training for e: ng and the ded; and s may any time. g competence ng program	V 337				

Division of Health Service Regulation

STATE FORM 6899 ETSF11 If continuation sheet 13 of 17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
MHL026-978		B. WING		04/2	04/20/2022		
EXCEL CARE AGENCY INCORPORATED 1903 BRID			DRESS, CITY, S DGER STREI ETTEVILLE				
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 537	(2) Trainers so by scoring 100% or teaching the use of and isolation time-of (3) Trainers so by scoring a passin instructor training p (4) The trainic competency-based objectives, measurable method failing the course. (5) The contest service provider plate approved by the Divito Subparagraph (j) (6) Acceptable shall include, but note: (A) understan (B) methods course; (C) evaluation (D) document (7) Trainers so annually and demon of seclusion, physic time-out, as specific Rule. (8) Trainers so in teaching the use least two times with coach.	shall demonstrates that the seclusion, photosome seclusion, photosome shall demonstrate that the seclusion of the instructor that the shall be retrained in Paragraphall be current and the shall be current shall shall be current shall	rate competence sting in an surable learning written and by e objectives and he passing or ructor training the shall be DD/SAS pursuant le. raining programs o, presentation telearner; content of the erformance; and ares. He at least etence in the use and isolation ph (a) of this ontly trained in eiched experience interventions at view by the	V 537			

Division of Health Service Regulation

STATE FORM 6899 ETSF11 If continuation sheet 14 of 17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		MHL026-97	8	B. WING		04/:	20/2022
	PROVIDER OR SUPPLIER	RPORATED	1903 BRII	DRESS, CITY, S DGER STREI ETTEVILLE			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 537 Continued From page 14  (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (I) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers.		V 537					
	This Rule is not me Based on record re failed to ensure one Professional (QP)) updates in seclusio isolation time-out. T	view and intervie e of two staff (Qua received annual t n, physical restra	w, the facility alified training				
	Review on 04/20/22 revealed: - Date of hire: 04/2 - National Crisis Intupdates in seclusion isolation time-out expenses.	1/21. erventions Plus (l n, physical restra	NCI+) training int and				

Division of Health Service Regulation

STATE FORM 6899 ETSF11 If continuation sheet 15 of 17

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	COMPLE	
MHL026-978		B. WING		04/20/2022		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	•	
EXCEL (	CARE AGENCY INCOM	PORATED	OGER STRE			
(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)	LD BE	(X5) COMPLETE DATE
V 537	- No current training physical restraint and Interview on 04/20/ She understood a current training upon restraint and isolational restrictive intervention 27G .0303(c) Facilion 10A NCAC 27G .03 EXTERIOR REQUICO Each facility and maintained in a safemanner and shall be	g updates in seclusion, and isolation time-out.  22 the QP stated: Il staff were required to have lates in seclusion, physical on time-out. the required training in ions.  ty and Grounds Maintenance  603 LOCATION AND	V 537			
	was not maintained and orderly manner Observation on 04/8:50am revealed: - 4 mattresses on the facility. Several piece the right of the facil scattered on the green The yard outside I facility and vines in The wall underned	on and interview, the facility in a safe, clean, attractive				

Division of Health Service Regulation

STATE FORM 6899 ETSF11 If continuation sheet 16 of 17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED		
MHL026-978			B. WING	B. WING			
	PROVIDER OR SUPPLIER	PORATED 1903 BR	DDRESS, CITY, STATE, ZIP CODE  DGER STREET  YETTEVILLE, NC 28301				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
V 736	- The kitchen had a - Client #1 and clier dresser handles. Th dust on the surface - Client #2's bedrood dust on the surface - Client #4's bedrood portion of wall near - Client #2 and clier bulb that did not wo - The bathroom use had one of two light - The activity room that worked  Interview on the Qu - She was suppose thrown away the pro-	missing drawer.  In #3's bedroom had 5 missing the window sill had a layer of the bottom.  In #4's bathroom had one light window the mirror fixture.  In the window wind					

6899

Division of Health Service Regulation
STATE FORM

ETSF11 If continuation sheet 17 of 17