| STATE                    | MENT OF DEFICIENCIES   | X1) PROVIDER/  | STIDDLIEDICLIA      |                     | VO MILLTIDLE CONCEDURATION  |  |                             |
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|                          | AN OF CORRECTION   | IDENTIFICATION   |                     |                     | X2) MULTIPLE CONSTRUCTION   | X3) DATE SURVEY<br>COMPLETED   |                             |
|                          |  |  |                     |                     | A. BUILDING:  |  |                             |
|                          |  | MHL026-978   |                     |                     | B. WING   | 4/20/2022  |                             |
| NAME OF                  | PROVIDER OR SUPPLIER   |  | STREET ADDRESS      | S, CITY, STA        | TE, ZIP CODE  |  |                             |
| EXCEL                    | CARE AGENCY INCOPORATED  |  | 1903<br>EAST FAYETT |                     | R STREET<br>NC 28301  |  |                             |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENC<br>(EACH DEFICIENCY MUST BE PRECED<br>REGULATORY OR LSC IDENTIFYING IN  | ED BY FULL   |                     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO T  | ON SHOULD BE   | X5)<br>COMPLE<br>TE<br>DATE |
| V00                      | INITIAL COMMENTS V 000 An annual survey was completed or 2022. Deficiencies were cited. This facility is licensed for the follo category: 10A NCAC 27G .5600A Stationing for Adults with Mental Illness This facility is licensed for 6 and curcensus of 4. The survey sample consudits of 3 current clients. V 112 27G .0205 (C-D) Assessment/Treatment/Habilitation 10A NCAC 27G .0205 ASSESSME TREATMENT/HABILITATION OF PLAN (c) The plan shall be developed base assessment, and in partnership with a legally responsible person or both, wof admission for clients who are expreceive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipachieved by provision of the service projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan annually in consultation with the clie responsible person or both; (5) basis for evaluation or assessment outcome achievement; and (6) written consent or agreement by the responsible party, or a written statem provider stating why such consent constained. | wing service Supervised ss. rrently has a sisted of  Plan NT AND R SERVICE d on the the client or within 30 days ected to  atted to be and a  at least nt or legally t of the client or ent by the |                     | V000                | Assessment/Treatment/Habi 10A NCAC 27G .0205 ASS TREATMENT/HABILITAT PLAN Excel Care QP has completed an with client, reviewed and updated projected achievement of April 20 Treatment plan included: Steps to implement goals Signed consent for treatment ind participated in developing plan of  RECEIV JUN 2 2 2  DHSR-MH Licensu | ESSMENT AND FION OR SERVICE anual Treatment plan IPCP to reflect outcome 23. | 5/4/2022                    |
| Division of<br>LABORATO  | Health Service Regulation RY DIRECTOR'S OR PROVIDER/SUPPLIER I   | REPRESENTATIVE   | S SIGNATURE         | Ti                  | TLE   | (XI6 DATE  |                             |
|                          |  |  | Bulley              |                     | Director  | 6/16/2   | 022                         |
| STATE FO                 | RM   | 6899   | J                   | ETSI                |   |  |                             |
|                          |  |  |                     |                     | Jane Carlotte   |  |                             |

|                          | MENT OF DEFICIENCIES<br>AN OF CORRECTION  | X1) PROVIDER/SUPPLIER/CL<br>IDENTIFICATION NUMBER  | .IA                 | X2) MULTIPLE CONSTRUCTION  | X3) DATE SURVEY  | Y                       |
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|                          | PROVIDER OR SUPPLIER  |  | DDRESS, CITY        | , STATE, ZIP CODE  |  |                         |
| EXCEL                    | CARE AGENCY INCOPORATED   |  |                     | DGER STREET<br>LE, NC 28301  |  |                         |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEIN REGULATORY OR LSC IDENTIFYING II   | DED BY FULL  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE AP   | OULD BE  | X5)<br>COMPLETE<br>DATE |
| V112                     | Continued From page 1 V 112 This Rule is not met as evide Based on record review and it failed to assure treatment pla reviewed annually, signed wr failed to develop and impleme strategies to address client net three audited clients (#1, #2 a findings are: Finding #1: Review on 04/20/22 of client a revealed: - 69 year old male Admission date of 08/27/21 Diagnoses of Borderline Personalit Bipolar Disorder, Mood Disorder, H Hypothyroidism and Generalized Ar - FL-2 dated 12/09/21 - Incontinent Review on 04/20/22 of client #1' Centered-Profile (PCP) dated 04 No signed consent for PCP No strategies to address client # incontinence of bladder No annual review completed in Finding #2: Review on 04/20/22 of client #2's revealed: - 65 year old female Admission date 08/27/21 Diagnoses of Generalized Anxie Mood Disorder, Borderline Person | nced by: interview the facility ns were at least itten consent and ent goals and eeds for three of and #3). The  #1's record  ty Disorder, fypertension, nxiety. of Bladder. s Person /08/21.  #1's  April 2022. s record  ety Disorder, | V112                | Continued From page 1 V 12  Assessment/Treatment/Habilita 10A NCAC 27G .0205 ASSESSM TREATMENT/HABILITATION PLAN.  QP has reviewed PCP with client a client fully participated with dever Centered plan. QP and client iden focusing on Clients Mental health, QP implemented Strategies and sterm care staff will follow in order to strategies. Targeted date to comprexceed 12 months after which goal upon completion  All PCP are signed by all responsite Statement of concern or disagreem by clients and QP copy of all documents to decients file. And in day to day with the clients file. And in day to day with the clients file of the province o | ation Plan IENT AND OR SERVICE and ensured that loping the Person tified goals needs, interests. The sps which excel apport client lete goals will not s will be reviewed to be parties. The sent is also signed ments are placed in work book.  The signed such as oped. Client will the the rest room in | 4/23/2022               |
|                          | Health Service Regulation<br>RY DIRECTOR'S OR PROVIDER/SUPPLIE  | R REPRESENTATIVE'S SIGNA   |                     | TITLE (OP/DMeetor  | X16 DATE   | 22                      |
| STATE FO                 | PRM   | 6899   | A.                  |  | n of sheet 2 of 17   |                         |
|                          |   |  |                     | Continuatio  | OI SHOCK Z UI I/   |                         |

|                            | MENT OF DEFICIENCIES  AN OF CORRECTION  | X1) PROVIDER/SUPPLIER/OF IDENTIFICATION NUMBER  |                     | X2) MULTIPLE CONSTRUCTION  | X3) DATE SURVE<br>COMPLETED  | ΞY                      |
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|                            |   |   |                     | A. BUILDING:   |  |                         |
|                            |   | MHL026-978  |                     | B. WING  | 4/20/2022  |                         |
| NAME OF I                  | PROVIDER OR SUPPLIER  | STREET  | ADDRESS, CITY, S    | STATE, ZIP CODE  |  | -                       |
| EXCEL                      | CARE AGENCY INCOPORATED   |   | 1903 BRIDO          | GER STREET   |  |                         |
|                            |   |   | FAYETTEVILL         |  |  |                         |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF D<br>(EACH DEFICIENCY MUST BE<br>REGULATORY OR LSC IDENTI  | PRECEDED BY FULL  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP   | ULD BE   | X5)<br>COMPLETE<br>DATE |
| V112 V114                  | Continued From page 2 V 11 bipolar Disorder, Allergic Rh Hypertension. Review on 04/20/22 of client 04/10/21 revealed: - No annual review complete Finding #3: Review on 04/20/22 of client revealed: - 60 year old male Admission date of 08/27/21 - Diagnoses of Schizophrenia esophageal Reflux Disease, Anxiety and Pulmonary Disease. Review on 04/20/22 of client Centered-Profile (PCP) dated - No signed consent for PCP - No annual review complete Interview on 04/20/22 the Qu (QP) stated: - She understood the client Previewed annually and signed responsible party Client #1 was incontinent of She understood client #1's include strategies to address V 114 27G .0207 Emergency 10A NCAC 27G .0207 EMER A ND SUPPLIES (a) A written fire plan for each area-wide disaster plan shall shall be approved by the app authority. (b) The plan shall be made as Health Service Regulation | #2's PCP dated d in April 2022. #3's record  a, Gastro Chronic Obstructive #1's Person d 04/10/21. d in April 2022. alified Professional CP's need to be d by the client or bladder at times. PCP needed to his incontinence. Plans and Supplies GENCY PLANS a facility and be developed and ropriate local | V112                | Assessment/Treatment/Habilitat 10A NCAC 27G .0205 ASSESSMI TREATMENT/HABILITATION CPLAN.  QP has reviewed PCP with client a client fully participated with develor Centered plan. QP and client identification focusing on Clients Mental health, and QP implemented Strategies and step care staff will follow in order to supeffectively. Targeted date to complanot exceed 12 months after which greviewed upon completion  All PCP are signed by all responsib Statement of concern or disagreeme by clients and QP . copy of all docuplaced in the clients file. And in day book.  V 114 27G .0207 Emergency Supplies 10A NCAC 27G .0207 EMER PLANS A ND SUPPLIES  Excel Care has a written plan . To been made available to staff. | ent and or service  Ind ensured that oping the Person fied goals needs, interests. In the ensured that oping the Person fied goals needs, interests. In the ensured that oping the Person fied goals needs, interests. In the ensured that oping the Person fied goals interests. In the ensured that oping the Person fied goals interests. In the ensured that oping the Person fied goals interests. In the ensured that oping the Person fied goals interests. In the ensured that oping the Person fied goals interests. In the ensured that oping the Person fied goals interests. In the ensured that oping the Person fied goals interests. In the ensured that oping the Person fied goals interests. In the ensured that oping the Person fied goals interests. In the ensured that oping the Person fied goals interests. In the ensured that oping the Person fied goals interests. In the ensured that oping the Person fied goals interests. In the ensured that oping the Person fied goals interests. In the ensured that oping the | 5/4/2022                |
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| 5-430-5-500-5-500-5-5-5-6-6-6-6-6-6-6-6-6-6-   | MENT OF DEFICIENCIES<br>LAN OF CORRECTION   | X1) PROVIDER/SUPPLIER/CLI<br>IDENTIFICATION NUMBER   | A                        | X2) MULTIPLE CONSTRUCTION   | X3) DATE SURV   | /EY                                |
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| 1.71.070 1.7   |   |  |                          | A. BUILDING:  |   |                                    |
|  |   | MHL026-978   |                          | B. WING   | 4/20/2022   |                                    |
| NAME OF  | PROVIDER OR SUPPLIER  | CTDEET AD  | DDESS CITY OF            | FATE ZID CODE   |   |                                    |
|  |   |  | DRESS, CITY, S           |   |   |                                    |
| EXCEL  | CARE AGENCY INCOPORATED   |  | 1903 BRIDG<br>YETTEVILLE |   |   |                                    |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIEN<br>(EACH DEFICIENCY MUST BE PRECE<br>REGULATORY OR LSC IDENTIFYING I  | DED BY FULL  | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE   |   | X5)<br>COMPLETE<br>DATE            |
| V114 Continued From page 3 V 114 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 |   |  | V114                     | V 114 27G .0207 Emergency Plans and Supplies<br>10A NCAC 27G .0207 EMERGENCY PLANS<br>A ND SUPPLIES   |   |                                    |
|  | 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 review and interview the facility failed to have fire and disaster drills held at least quarterly and repeated on each shift. The findings |  |                          | Fire and disaster drill is being conducted by all shifts  |   | Last day<br>completed<br>6/16/2022 |
|  | are: Review on 04/20/22 of facility October 2021 thru March 202 - No documented fire or disas quarter of 2021 No disaster drills documente quarter of 2022.   | 22 revealed:<br>ster drills for the 4th<br>ed for the 1st                                      |                          |   |   |                                    |
| V118   | Interview on 04/20/22 the Qu (QP) stated: - She and staff #1 worked at the She was unable to locate the drills for 2021 She understood fire and discrequired to be completed qual each shift. V 118 27G .0209 (C) Medication 10A NCAC 27G .0209 MEDIC REQUIREMENTS (c) Medication administration:                           | the facility. e fire and disaster aster drills were rterly and repeated on Requirements CATION | V118                     | V 118 27G .0209 (C) Medication 10A NCAC 27G .0209 MEDICAT QP ensures that all medications addocumented.  QP reviews medication records we ensure to make sure that there are of not documenting mediations aft administered. Medication overvie completed with emphasis on documenting mediately after administrations medications. | ministered are weekly to no over sight er they are w training was menting | 6/5/2022                           |
| Division o   | L<br>f Health Service Regulation<br>DRY DIRECTOR'S OR PROVIDER/SUPPLII  | ER REPRESENTATIVE'S SIGNA  | TURE                     | TITLE   | ( X16   | DATE ,                             |
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| STATE                    | MENT OF DEFICIENCIES  | X1) PROVIDER/   |           | .IA                 | X2) MULTIPLE CONSTRUCTION  | X3) DATE S  | URVEY                   |
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| AND PI                   | AN OF CORRECTION  | IDENTIFICATION  | N NUMBER  |                     | TM -   | COMPLETE  | D                       |
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|                          |   | MHL026-978  |           |                     | B. WING  | 4/20/202  | 2                       |
| NAME OF                  | PROVIDER OR SUPPLIER  |   | STREET AL | DDRESS, CITY,       | STATE, ZIP CODE  |   |                         |
| EXCEL                    | CARE AGENCY INCOPORATED   | )   | EAST FA   |                     | GER STREET<br>LE, NC 28301   |   |                         |
| (X4) ID<br>PREFIX<br>TAG | UMMARY STATEMENT OF DEFICIE<br>(EACH DEFICIENCY MUST BE PREC<br>REGULATORY OR LSC IDENTIFYIN  | CEDED BY FULL   | 161       | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE AP   | OULD BE   | X5)<br>COMPLETE<br>DATE |
| V118                     | Continued From page 4 V 118  (1) Prescription or non-prescription only be administered to a client on order of a person authorized by law drugs.  (2) Medications shall be self-admir clients only when authorized in writclient's physician.  (3) Medications, including injection administered only by licensed persunlicensed persons trained by a regnurse, pharmacist or other legally qualifie privileged to prepare and administer medications.  (4) A Medication Administration R all drugs administered to each client kept current. Medications administereds recorded immediately after administ MAR is to include the following:  (A) client's name;  (B) name, strength, and quantity of  (C) instructions for administering the drug.  (5) Client requests for medication checks shall be recorded and kept will followed up by appointment or with a physician.  This Rule is not met as evidenced be Based on record reviews and intervifacility failed to keep the MARs cut two of three audited clients (#2 and findings are: Division. | the written to prescribe histered by ting by the his, shall be ons, or by istered diperson and record (MAR) of timust be shall be tration. The the drug; he | *         | V118                | V 118 27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATE  QP ensures that all medications adra are documented. QP reviews medi records weekly to ensure to make s there are no over sight of not documedications after they are administ Medication overview training was to further train staff on medication administration with emphasis on do immediately after administrations of medications. | ministered cation ure that nenting ered completed socumenting | 6/5/2022                |
| Division o               | f Health Service Regulation   | ***   |           |                     |  |   |                         |
| LABORATO                 | PRY DIRECTOR'S OR PROVIDER/SUPPLI   | ER REPRESENTAT  |           | ATURE               | TITLE Divedor (X   | 16 DATE   | 116/2022                |
| STATE FO                 | DRM 6899  | E   | TSF11     | U                   | Continuation of sheet 5 of   | 17  |                         |

| 1                        | MENT OF DEFICIENCIES   | X1) PROVIDER/SUPPLIER/C  | CLIA                | X2) MULTIPLE CONSTRUCTION  | X3) DATE SUF  | RVEY                    |
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| NAME OF                  | PROVIDER OR SUPPLIER   | STREET   | ADDRESS, CIT        | TY, STATE, ZIP CODE  |   |                         |
| EXCEL                    | CARE AGENCY INCOPORATED  |  |                     | IDGER STREET<br>EVILLE, NC 28301   | -   |                         |
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| V118                     | Continued From page 5 V 118 Finding #1: Review on 04/20/22 of client revealed: - 65 year old female Admission date 08/27/21 Diagnoses of Generalized A Mood Disorder, Borderline Pe Bipolar Disorder, Allergic Rhi Hypertension. Review on 04/20/22 of client medication orders revealed: 04/16/22 - Levothyroxine (treats Hypot micrograms (mcg) take once 02/01/22 - Ativan (treats Anxiety) 1 mill three times daily. 01/03/22 - Metoprolol (treats Hypertens twice daily. 12/07/21 - Austedo (treats involuntary in 1 mg - take three times daily. Review on 04/20/22 of client and April 2022 MARs reveale April 2022 - Levothyroxine 100mcg - trar administered 04/17/22 thru 04 - Austedo - No staff initials to administration from 04/01/22 March 2022 - Ativan - No staff initials to incadministration on 03/04/22 and - Metoprolol - No staff initials to incadministration on 03/04/22 and - Metoprolol - No staff initials to incadministration on 03/04/22 and - Metoprolol - No staff initials to incadministration on 03/04/22 and - Metoprolol - No staff initials to incadministration on 03/04/22 and - Metoprolol - No staff initials to incadministration on 03/04/22 and - Metoprolol - No staff initials to incadministration on 03/04/22 and - Metoprolol - No staff initials to incadministration on 03/04/22 and - Metoprolol - No staff initials to incadministration on 03/04/22 and - Metoprolol - No staff initials to incadministration on 03/04/22 and - Metoprolol - No staff initials to incadministration on 03/04/22 and - Metoprolol - No staff initials to incadministration on 03/04/22 and - Metoprolol - No staff initials to incadministration on 03/04/22 and - Metoprolol - No staff initials to incadministration on 03/04/22 and - Metoprolol - No staff initials to incadministration on 03/04/22 and - Metoprolol - No staff initials to incadministration on 03/04/22 and - Metoprolol - No staff initials to incadministration on 03/04/22 and - Metoprolol - No staff initials to incadministration on 03/04/22 and - Metoprolol - No staff initials to incadministr | #2's record  Anxiety Disorder, ersonality Disorder, nitis and  #2's signed  hyroidism) 112 daily.  igrams (mg) - take  sion) 25mg - take  muscle movements)  #2's March 2022 d:  ascribed as  1/19/22.  indicate thru 04/03/22.  dicate d 03/05/22 at 2pm. | V118                | V 118 27G .0209 (C) Medication Requitor 10A NCAC 27G .0209 MEDICATION  QP ensures that all medications ad are documented.  QP reviews medication records we ensure to make sure that there are sight of not documenting mediations are administered.  Medication overview training was of further train staff on medication administer administer of the staff of the staff on medication administer of the staff of | ministered ekly to no over s after they ompleted to | On going 6/5/2022       |
| Division of              | Health Service Regulation  | ED DEDDECENTATIVE CO.  | NATURE              | TITLE /  | V.10 1  | 1.71=                   |
| LABUKATO                 | RY DIRECTOR'S OR PROVIDER/SUPPLIE  | REPRESENTATIVE'S SIGN  | NATURE              | 10p Divector (   | X16 DATE (  | 116/2022                |
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| STATEME                  | ENT OF DEFICIENCIES   | X1) PROVIDER/SUPPLIER/CLIA  |                     | VOLANIII TIDI E CONCEDITORIO  |  |                           |
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|                          | ENT OF DEFICIENCIES<br>N OF CORRECTION  | IDENTIFICATION NUMBER   |                     | X2) MULTIPLE CONSTRUCTION   | X3) DATE SUR<br>COMPLETED  | VEY                       |
|                          |   |   |                     | A. BUILDING:  |  |                           |
|                          |   | MHL026-978  |                     | B. WING   | 4/20/2022  |                           |
| NAME OF P                | ROVIDER OR SUPPLIER   | STREET ADDR   | ESS, CITY, ST       | ATE, ZIP CODE   |  |                           |
| EXCEL C                  | ARE AGENCY INCOPORATED  | 19  | 03 BRIDGE           | R STREET  |  |                           |
|                          |   | EAST FAYE   |                     |   |  |                           |
|                          |   |   |                     |   |  |                           |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIEN<br>(EACH DEFICIENCY MUST BE PRECE<br>REGULATORY OR LSC IDENTIFYING  | DED BY FULL   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE A   | HOULD BE   | X5)<br>COMPLETE<br>DATE   |
| V536                     | Continued From page 6 V 11 administration twice daily on 03/03/22. Interview on 04/20/22 client received her medications da Finding #2: Review on 04/20/22 of client revealed: - 60 year old male Admission date of 08/27/21 - Diagnoses of Schizophrenia Reflux Disease, Anxiety and Pulmonary Disease. Review on 04/20/22 of client physician orders dated 12/09 - Alphagan (treats eye press administer one drop in each Review 04/20/22 of client #3' March 2022 and April 2022 Mollowing transcribed entry: - Alphagan 0.1% - administer eye once daily Staff initials to indicate the Madministered once daily. Interview on 04/20/22 the Quistated: - All clients received their me by the physician Staff may have forgotten to administering medications She would contact the phart transcribed entries. V 536 27E .0107 Client Rights Rest. Int. | #2 stated she ily as ordered.  #3's record  .a, Gastro esophageal Chronic Obstructive  #3's signed 9/21 revealed: ure) 0.1% - eye twice daily. 's February 2022, MARs revealed the  r one drop in each  Alphagan was ealified Professional dications as ordered initial MARs after  macy to correct the | V118                | QP ensures that all medication administered are documented.  QP reviews medication record ensure to make sure that there sight of not documenting medithey are administered.  Medication overview training of completed.  The pharmacy was contacted the conflict with eye drop administered and it has been corrected.  V 536 27E .0107 Client Rights on Alt to Rest.  Trainings was completed .  Training will be completed annual. | ds weekly to e are no over ations after was in regards to nistration | On going 6/5/2022 May MAR |
| Division of H            | ealth Service Regulation  |   |                     |   |  |                           |
| LABORATOR                | / DIRECTOR'S OR PROVIDER/SUPPLIE  | R REPRESENTATIVE'S SIGNATUR   | RE 1/1              | TITLE OP/DIVLETY X16  | DATE 6/1/  | 1222                      |
| STATE FOR                | M   | 6899  |                     | GF11 Continuation of sheet 7 of 17  |  | 170-                      |

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| and the same state of the same | ENT OF DEFICIENCIES<br>N OF CORRECTION   | X1) PROVIDER/SUPPLI<br>IDENTIFICATION NUME   |                                       | X2)           | MULTIPLE CONSTRUCTION   | X3) DATE SURVE<br>COMPLETED | ΞY                      |
|                                |  |  |                                       | A. B          | UILDING:  |                             |                         |
|                                |  | MHL026-978   |                                       | B. W          | VING  | 4/20/2022                   |                         |
| NAME OF P                      | ROVIDER OR SUPPLIER  | STRE   | EET ADDRESS, CIT                      | Y, STATE, 2   | ZIP CODE  |                             |                         |
| EXCEL C                        | ARE AGENCY INCOPORATED   | )  | 1903 BR                               | DGFR S        | TREET   |                             |                         |
|                                |  |  | ST FAYETTEVI                          |               |   |                             |                         |
| (X4) ID                        | SUMMARY STATEMENT OF DEFICI  | ENCIES   |                                       | ID            | DROVIDEDIS DI AN OF COD   | DECTION                     | T                       |
| PRÉFIX<br>TAG                  | (EACH DEFICIENCY MUST BE PREC<br>REGULATORY OR LSC IDENTIFYING   | CEDED BY FULL  |                                       | PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO T  | ON SHOULD BE                | X5)<br>COMPLETE<br>DATE |
| V536                           | Continued From page 7 V standard Standa | INING ON TRICTIVE  Int policies and the use of alternative test to people with service providers, unteers, shall by successfully munication skills and an environment in inent danger of abusabilities or others at ted. establish training es, monitor for interte they acted on date they are acted to the date of the da | d<br>use<br>or<br>rnal<br>ata<br>n of | V536          | 10A NCAC 27E .0107 ALTERNATIVES TO R INTERVENTIONS  Staff received Training Tra completed annually.  All new employees will be t resuming work. | ESTRICTIVE                  | 4/26/2022               |
| Division of H                  | ealth Service Regulation<br>/ DIRECTOR'S OR PROVIDER/SUPPLIE   | ER REPRESENTATIVE'S  |                                       |               | DIP DIRECTOR  | ( X16                       | DATE,                   |
| STATE FOR                      | М  | 6899   | PALEUSETS                             | F11           | Continuation of sheet 8 o   | f 17                        | 6/11/4/22               |

|                          | T OF DEFICIENCIES<br>OF CORRECTION   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER  |                     | X2) MULTIPLE CONSTRUCTION  | X3) DATE SURV<br>COMPLETED | /EY                     |
|--------------------------|--|--|---------------------|--|----------------------------|-------------------------|
|                          |  |  |                     | A. BUILDING:   |                            |                         |
|                          |  | MHL026-978   |                     | B. WING  | 4/20/2022                  |                         |
|                          | NAME OF PROVIDER OR SUPPL  |  | STREET ADD          | DRESS, CITY, STATE, ZIP CODE   |                            |                         |
|                          | EXCEL CARE AGENCY II   | NCOPORATED   |                     | 1903 BRIDGER STREET<br>YETTEVILLE, NC 28301  |                            |                         |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEF<br>(EACH DEFICIENCY MUST BE P<br>REGULATORY OR LSC IDENTIF  | RECEDED BY FULL  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE                                       | SHOULD BE                  | X5)<br>COMPLETE<br>DATE |
| V536                     | Continued From page 8 V 536 (3) recognizing the effect of in external stressors that may aff disabilities; (4) strategies for building post relationships with persons wit (5) recognizing cultural, envir organizational factors that may disabilities; (6) recognizing the importance assisting in the person's involved decisions about their life; (7) skills in assessing individuce escalating behavior; (8) communication strategies of and de-escalating potentially dand (9) positive behavioral support means for people with disabilitiactivities which directly opposes behaviors which are unsafe). (h) Service providers shall maid documentation of initial and reat least three years. (1) Documentation shall included (A) who participated in the train outcomes (pass/fail); (B) when and where they attend (C) instructor's name; (2) The Division of MH/DD/S/review/request this documentation and Requirements: (1) Trainers shall demonstrate the by scoring 100% on testing in a saimed at preventing, reducing a need for restrictive intervention (2) Trainers shall demonstrate of the program of t | nternal and feet people with stive in disabilities; commental and y affect people with se of and rement in making all risk for for defusing angerous behavior; as (providing ties to choose e or replace in tain fresher training for see in the ded; and for the ded; and the ded | V536                | 10A NCAC 27E .0107 TE ALTERNATIVES TO RESINTERVENTIONS  Training has been completed a subsequently continue annually | STRICTIVE                  | 4/26/2022               |
| Division of Heal         | th Service Regulation RECTOR'S OR PROVIDER/SUPPLIE   | ER REPRESENTATIVE'S SIGNATURE  | :                   | TITLE 00 0 0 Sta- but  | (X16 DATE (                | 10/1/0/20               |
| STATE FORM               |  | 6899 ETSF1   | ZMens               | Continuation of speet 9 of 17  | ( A TO DATE (              | x 1 1 1 1 3000          |

|                              | NT OF DEFICIENCIES<br>N OF CORRECTION   |  | IDENTIFICATION NUMBER      |     | MULTIPLE CONSTRUCTION  | X3) DATE SURVEY   | Y                       |
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|                              |   | MHL026-978   |                            |     | BUILDING:  | 4/20/2022   |                         |
| NAME OF PR                   | OVIDER OR SUPPLIER  | 300000000000000000000000000000000000000  | EET ADDRESS, CITY          |     |  | 4/20/2022   |                         |
| EXCEL CA                     | ARE AGENCY INCOPORATE   |  | 1903 BRII<br>ST FAYETTEVIL |     |  |   |                         |
| (X4) ID<br>PREFIX<br>TAG     | SUMMARY STATEMENT OF DEFI<br>(EACH DEFICIENCY MUST BE PR<br>REGULATORY OR LSC IDENTIFY  | CIENCIES<br>ECEDED BY FULL   | IC<br>Pi                   |     | PROVIDER'S PLAN OF CORI<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH  | N SHOULD BE   | X5)<br>COMPLETE<br>DATE |
| V536                         | Continued From page 9 V 536 (3) The training shall be competency-based, include me objectives, measurable testing observation of behavior) on the measurable methods to determ failing the course. (4) The content of the instructor service provider plans to emplor approved by the Division of M to Subparagraph (i)(5) of this F (5) Acceptable instructor trainition shall include but are not limited (A) understanding the adult lea (B) methods for teaching contectourse; (C) methods for evaluating train performance; and (D) documentation procedures. (6) Trainers shall have coached teaching a training program ain reducing and eliminating the neinterventions at least one time, review by the coach. (7) Trainers shall teach a training aimed at preventing, reducing a need for restrictive intervention annually. (8) Trainers shall complete a re- instructor training at least every (j) Service providers shall main documentation of initial and ref training for at least three years. (1) Documentation shall include (A) who participated in the train outcomes (pass/fail); (B) when and where attended; a (C) instructor's name. (2) The Division of MH/DD/SA request and review this document | easurable learning (written and by ose objectives and ine passing or or training the oy shall be H/DD/SAS pursuant cule. Ing programs If to presentation of: rner; Int of the Interpolation Interpolat | Ve                         | 536 | 10A NCAC 27E .0107 ALTERNATIVES TO RINTERVENTIONS  Training was completed continue to receive annual and training on the same teapplied if or when it is read to a training and the same teapplied if or when it is read and qualified I | ESTRICTIVE  I. And will ual training.  receive chnique to chnique is equired. | 4/26/2022               |
| Division of He<br>LABORATORY | request and review this documer<br>alth Service Regulation<br>DIRECTOR'S OR PROVIDER/SUPPLI   |  | SIGNATURE                  |     | TITLE 10 1/22  | (X16 DATE   |                         |
| STATE FORM                   |   | ETS  | Rucey                      |     | Continuation of sheet 10 of 17   | (X16 DATE 4/16  | 12022                   |
|                              | 3333  |  |                            |     | Sommulation of sheet 10 01 17  |   |                         |

# Division OF HEALTH SERVICE REGULATIONS

STATEMENT OF DEFICIENCIES

| The state of the s | MENT OF DEFICIENCIES  | X1) PROVIDER/SUPPLIER/<br>IDENTIFICATION NUMBER   | CLIA                |                                       | X2) MULTIPLE CONSTRUCTION  | X3) DATE SURV                                  | /EY       |
|--|---|---|---------------------|---------------------------------------|--|--|-----------|
| AND PI   | LAN OF CORRECTION   | IDENTIFICATION NOWIBER  |                     |                                       |  | COMPLETED                                      |           |
|  |   |   |                     |                                       | A. BUILDING:   |  |           |
|  |   | MHL026-978  |                     |                                       | B. WING  | 4/20/2022                                      |           |
| NAME OF  | PROVIDER OR SUPPLIER  | STREET  | ADDRESS, C          | SITY, STA                             | ATE, ZIP CODE  |  |           |
| EXCEL  | CARE AGENCY INCOPORATED   | f   |                     |                                       |  |  |           |
| LXOLL  | CARE AGENOT INCOPORATED   |   | FAYETTE\            |                                       | R STREET<br>NC 28301   |  |           |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENT<br>(EACH DEFICIENCY MUST BE PRECED<br>REGULATORY OR LSC IDENTIFYING IN   | DED BY FULL   | ID<br>PREFIX<br>TAG | (EAC                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE  |  |           |
| V536   | Continued From page 10 V 536 (k) Qualifications of Coaches: (1) Coaches shall meet all preparequirements as a trainer. (2) Coaches shall teach at least the course which is being coaches (3) Coaches shall demonstrate competence by completion of contrain-the-trainer instruction. (l) Documentation shall be the same as for trainers.  This  This Rule is not met as evidence Based on record review and interfailed to ensure one of two staff (Professional (QP)) received annumentation and interfailed to ensure one of two staff (Professional (QP)) received annumentations.  The findings are:  Review on 04/20/22 of the QP's precord revealed:  Date of hire: 04/21/21.  National Crisis Interventions Platraining updates in alternatives to restrictive expired effective March 2022.  No current training updates in a restrictive interventions.  Interview on 04/20/22 the QP states the understood all staff were recurrent training updates in alternatives in alternative interventions.  She would obtain the required training updates in state of the current training updates in alternative interventions. | hree times ed.  paching or ame preparation  d by: rview, the facility (Qualified lal training live  personnel  us (NCI+)  ve interventions  Iternatives to  ted: quired to have stives to | V536                | Trair received All states technology. | NCAC 27E .0107 TRAINING ERNATIVES TO RESTRICT ERVENTIONS  ling was completed. And will ve annual training.  aff will continue to receive trame technique to ensure that ique is applied if or when it is cell care staff will receive their training and qualified licensed trainer. | continue to aining on at the same is required. | 4/26/2022 |
| Division   | alternatives to restrictive interven  | tions.  |                     |                                       | (A.)   |  |           |
| LABORAT  | of Health Service Regulation ORY DIRECTOR'S OR PROVIDER/SUP   | DI IED DEDDECEMEATER  | C CIONATT           | Dr 21                                 | well molar   |  | 1.11/2    |
| STATE F  | ORM   | 6899  | 5 SIUNATU           | KE P                                  | ETSF11 Continuation of   | TX16 DATE sheet 11 of 17                       | 01110/2   |

|                          | MENT OF DEFICIENCIES<br>AN OF CORRECTION   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER   | )                    | (2) MULTIPLE CONSTRUCTION  | X3) DATE SURVE   | Υ                       |
|--------------------------|--|---|----------------------|--|--|-------------------------|
|                          |  |   | A                    | A. BUILDING:   |  |                         |
|                          |  | MHL026-978  |                      | 3. WING  | 4/20/2022  |                         |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET ADDRESS  | , CITY, STAT         | E, ZIP CODE  |  |                         |
| EXCEL                    | CARE AGENCY INCOPORATE   | D 1903<br>EAST FAYETTI  | BRIDGER<br>EVILLE, N | STREET<br>C 28301  |  |                         |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICI<br>(EACH DEFICIENCY MUST BE PREC<br>REGULATORY OR LSC IDENTIFYIN | CEDED BY FULL   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO TH   | N SHOULD BE  | X5)<br>COMPLETE<br>DATE |
| V 537                    | to   | IG IN FRAINT AND  Ind isolation by staff who have ted and alternatives all ensure that reminate these demonstrated  to people with itation plan staff including dents or g in the use of solation time-out ons until the ence is  training is inpletion of ind eliminating ins. incy-based, itives, it observation of measurable ailing the course. be completed ally (minimum annually). service approved by | V 537                | 10A NCAC 27E .0107 TALTERNATIVES TO REINTERVENTIONS  Training was completed continue to receive annually receive refrest to annually receive refrest All staff will continue to reconthe same technique to the same technique is apwhen it is required.  All excel care staff will receive from a trained and qualified like | RAINING ON ESTRICTIVE  And will last training.  Shall undergo and, continue sher course.  Ecceive training of ensure that oplied if or the course we their training over their training of the course. | 4/26/2022               |
| Division of              | Paragraph (g) of this Rule.  Health Service Regulation                                       |   |                      |  |  |                         |
| LABORATO                 | RY DIRECTOR'S OR PROVIDER/SUPPL  | ER REPRESENTATIVE'S SIGNATURE   | - 4                  | TITLE COP/AMerha   | (X16 DATE  | 11/2012                 |
| STATE FO                 | PRM 6899   | ETSF11  | Conti                | nuation of sheet 12 of 17  | (0   | 114/20                  |
|                          |  |   |                      |  |  |                         |

|                          |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER  |                      | X2) MULTIPLE CONSTRUCTION  A. BUILDING:  | X3) DATE SURVE<br>COMPLETED | Y                       |
|--------------------------|--|--|----------------------|--|-----------------------------|-------------------------|
|                          |  | MHL026-978   |                      | B. WING  | 4/20/2022                   |                         |
| NAME OF                  | PROVIDER OR SUPPLIER   |  | RESS, CITY,          | STATE, ZIP CODE  | 4/20/2022                   |                         |
| EXCEL                    | CARE AGENCY INCOPORATE   | EAST FAY   | OGER STR<br>ÆTTEVILL | EET<br>E, NC 28301   |                             |                         |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIEN<br>(EACH DEFICIENCY MUST BE PRECED<br>REGULATORY OR LSC IDENTIFYING II   | DED BY FULL  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE AP   | OULD BE                     | X5)<br>COMPLETE<br>DATE |
|                          | Continued From page 12 V 537  (g) Acceptable training programs of but are not limited to, presentation of (1) refresher information on alternation the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to others); (3) emphasis on safety and respect frights and dignity of all persons invoconcepts of least restrictive intervenincremental steps in an intervention; (4) strategies for the safe implement of restrictive interventions; (5) the use of emergency safety interventions which include continue assessment and monitoring of the physychological well-being of the clier use of restraint throughout the durative restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including the importance and purpose; and (8) documentation methods/procedur (h) Service providers shall maintain documentation of initial and refresheat least three years. (1) Documentation shall include: (A) who participated in the training a outcomes (pass/fail); (B) when and where they attended; a (C) instructor's name. (2) The Division of MH/DD/SAS mareview/request this documentation at Training Requirements: (1) Trainers shall demonstrate competity scoring 100% on testing in a training and at preventing, reducing and elimed for restrictive intervention. | of: tives to  self and  or the olved (using tions and ); ation  ous tysical and at and the safe tion of the  neir  res.  or training for  and the and  any time. ing tence ing program | V 537                | IOA NCAC 27E .0107 TRAINING ALTERNATIVES TO RESTRICT INTERVENTIONS  Training was completed. And will receive annual training.  All staff will continue to receive tr same technique to ensure that the sapplied if or when it is required. | CONTINUE TO                 | 4/26/2022               |
| LABORATO<br>STATE FC     | RY DIRECTOR'S OR PROVIDER/SUPPLII  | ER REPRESENTATIVE'S SIGNATU  | JRE JEALLY           | - TITLE CEP/DIVERSIN   | (X16 DATE 10/1              | 6/2022                  |
| STATE PU                 | (Alaki)  | 5899 ETSF1   | 1'                   | Continuation of sh   | eet13 of 17                 |                         |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBE | R/CLIA<br>R              | X2) MULTIPLE CONSTRUCTION   | X3) DATE SURV<br>COMPLETED |           |  |
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|   |  | MUI 026 070                                |                          | A. BUILDING:  | _                          |           |  |
|   | MHL026-978   |  |                          | B. WING   | 4/20/2022                  |           |  |
| NAME OF PROVIDER OR SUPPLIER STRE                   |  |  | T ADDRESS, CIT           | Y, STATE, ZIP CODE  |                            |           |  |
| EXCEL   | . CARE AGENCY INCOPORAT  |  | BRIDGER ST<br>FAYETTEVIL | REET<br>.LE, NC 28301   |                            |           |  |
| (X4) ID<br>PREFIX<br>TAG                            | UMMARY STATEMENT OF DEFICIEN<br>(EACH DEFICIENCY MUST BE PREC<br>REGULATORY OR LSC IDENTIFYING | EDED BY FULL                               | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A   | X5)<br>COMPLETE<br>DATE    |           |  |
|   | ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)        |  | V 537                    | IOA NCAC 27E .0107 TRAINIT ALTERNATIVES TO RESTRICINTERVENTIONS  Training was completed. And wi receive annual training.  All staff will continue to receive same technique to ensure that the applied if or when it is required. | CTIVE  Il continue to      | 4/26/2022 |  |
| Jivision of<br>ABORATO                              | Health Service Regulation ORY DIRECTOR'S OR PROVIDER/SUPP                                      | LIER REPRESENTATIVE'S SIG                  | SNATURE                  | TITLE COP/DIVINGTON   | (X16 DATE 6                | 16/2022   |  |
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Continuation of sheet15 of 17

### **Division OF HEALTH SERVICE REGULATIONS**

|   |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER                                |                         | X2) MULTIPLE CONSTRUCTION | X3) DATE SUF<br>COMPLETED   | RVEY                    |                         |
|---|---|--|-------------------------|---------------------------|---|-------------------------|-------------------------|
|   |   |  |                         |                           | A. BUILDING:  |                         |                         |
|   |   | MHL026-978   |                         |                           | B. WING   | 4/20/2022               |                         |
| NAME O  | NAME OF DECLARATION   |  |                         | CITY ST                   | ATE, ZIP CODE   | 4/20/2022               |                         |
| EXCE  | . CARE AGENCY INCOPORATED   |  |                         |                           |   |                         |                         |
| EXOLI   | OARE AGENCY INCOPORATED   |  | 3 BRIDGER<br>T FAYETTE\ |                           |   |                         |                         |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCI<br>(EACH DEFICIENCY MUST BE PRECEDED<br>REGULATORY OR LSC IDENTIFYING INF   | BY FULL  | ID<br>PREFIX<br>TAG     | (EACI                     | TIDER'S PLAN OF CORRECTION<br>H CORRECTIVE ACTION SHOULD<br>S-REFERENCED TO THE APPROPI             | BE<br>RIATE             | X5)<br>COMPLETE<br>DATE |
| V 537   | Continued From page 14 V 537  (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 |  |                         | ALTE                      | NCAC 27E .0107 TRAINING<br>ERNATIVES TO RESTRICT<br>RVENTIONS                                       |                         |                         |
|   | 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  |  |                         |                           | Training was completed. And will continue to receive annual training.                               |                         |                         |
|   | requirements as a trainer.  (2) Coaches shall teach at least three times, the course which is being coached.  (3) Coaches shall demonstrate   |  |                         | Restr                     | hire, all new hires shall und ictive training and, continue ve refresher course.                    | ergo Non<br>to annually |                         |
|   | competence by completion of coartrain-the-trainer instruction.  (m) Documentation shall be the sapreparation as for trainers.   |  |                         | the sa                    | aff will continue to receive tra<br>ame technique to ensure tha<br>ique is applied if or when it is | t the same              |                         |
|   | This Rule is not met as evidenced Based on record review and intervential failed to ensure one of two staff (Oprofessional (QP)) received annual updates in seclusion, physical restriction time-out. The findings are Review on 04/20/22 of the QP's perevealed:  - Date of hire: 04/21/21.                                    | iew, the facility<br>Qualified<br>I training<br>raint and<br>e:<br>ersonnel record |                         | All extrained             | cel care staff will receive their tra<br>and qualified licensed trainer.                            | ning from a             |                         |
| District  | - National Crisis Interventions Plu<br>updates in seclusion, physical restr<br>isolation time-out expired effective   | aint and   |                         |                           |   |                         |                         |
| Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE DIVINEL NV (X16 DATE 6/16/2072 |   |  |                         |                           |   |                         |                         |
| STATE FORM 6899 ETSF11 Continuation of sheet15 of 17  |   |  |                         |                           |   |                         |                         |

#### PRINTED: 04/25/2022 FORM APPROVED

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  MHL026-978 |                  | A. BUILDING:  | X3) DATE SURVEY<br>COMPLETED |           |                         |  |
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|   |  | WITIL026-976   |                  |   | B. WING                      | 4/20/2022 |                         |  |
|   | F PROVIDER OR SUPPLIER   |  |                  |   | ATE, ZIP CODE                |           |                         |  |
| EXCEL   | . CARE AGENCY INCOPORATED  |  | 1903<br>ST FAYET |   | ER STREET<br>NC 28301        |           |                         |  |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCE<br>(EACH DEFICIENCY MUST BE PRECEDE<br>REGULATORY OR LSC IDENTIFYING INI | D BY FULL  | ID PREFIX TAG    | (EACH   |                              |           | X5)<br>COMPLETE<br>DATE |  |
|   |  |  |                  | V 736 27G .0303(c) Facility and Grounds Maintenance.  The facility grounds has been cleaned up, the grass cut and will continue to be maintained by company.  Mattress used furniture and other debris has be removed from the facility grounds.  The wall underneath the dining table has been painted over. |                              |           | 4/20/2022               |  |
| Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE  (X16 DATE 6/16/2022 |  |  |                  |   |                              |           |                         |  |
| STATE F   | STATE FORM 6899 ETSF11 Continuation of sheet 16 of 17  |  |                  |   |                              |           |                         |  |

#### PRINTED: 04/25/2022 FORM APPROVED

### Division OF HEALTH SERVICE REGULATIONS

STATE FORM

|                                    |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER |                  | X2) MULTIPLE CONSTRUCTION X3) DATE S COMPLETE                  |  |                         |                  |
|------------------------------------|--|---|------------------|--|--|-------------------------|------------------|
|                                    |  | _   |                  |  | A. BUILDING:   |                         |                  |
|                                    |  | MHL026-978  |                  |  | B. WING  | 4/20/2022               |                  |
| NAME OF PROVIDER OR SUPPLIER STREE |  |   | ET ADDRESS       | , CITY, ST   | ATE, ZIP CODE  |                         |                  |
| EXCEL                              | CARE AGENCY INCOPORATED  |   | 1903<br>T FAYETT |  | R STREET<br>NC 28301   |                         |                  |
| (X4) ID<br>PREFIX<br>TAG           | REFIX REGULATORY OR LSC IDENTIFYING INFORMATION)                                     |   |                  | (EACH  | DER'S PLAN OF CORRECTION<br>CORRECTIVE ACTION SHOULD E<br>-REFERENCED TO THE APPROPRI  | X5)<br>COMPLETE<br>DATE |                  |
| V 736                              | (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |   | V 736            | Mainte  Missing  Client # repaired  Client # Client # replaced | g Kitchen drawer has been fixed #2's Window sills was cleaned up #4's bedroom = the wood that was d #2 and #4's bathroom bulb has bee #1 and #3's bathroom light bulbs h | 5/24/2022               |                  |
| Division of<br>LABORATO            | Health Service Regulation PRY DIRECTOR'S OR PROVIDER/SUPPLI                          | ER REPRESENTATIVE'S                                 |                  |  | TITLE  | ( X1                    | 6 DATE           |
|                                    |  |   | Rain             | y  | Op/Director  |                         | 6 DATE 6/16/2012 |

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Continuation of sheet 17 of 17