Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL023-171 | A. BUILDING: ______ B. WING ______ | 06/28/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **CLEVELAND CRISIS AND RECOVERY CENTER** | **609 NORTH WASHINGTON STREET SHELBY, NC 28150** |

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| V 000 | INITIAL COMMENTS<br><br>An annual survey was completed on June 28, 2018. Deficiencies were cited.<br><br>This facility is licensed for the following service categories: 10A NCAC 27G .3100 Nonhospital Medical Detoxification for Individuals who are Substance Abusers, 10A NCAC 27G .3300 Outpatient Detoxification for Substance Abuse, 10A NCAC 27G .5000 Facility Based Crisis Service for Individuals of all Disability Groups, and 10A NCAC 27G .1100 Partial Hospitalization for Individuals who are Acutely Mentally Ill. | V 000 | | |
| V 109 | 27G .0203 Privileging/Training Professionals<br><br>10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS<br>(a) There shall be no privileging requirements for qualified professionals or associate professionals.<br>(b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served.<br>(c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence.<br>(d) Competence shall be demonstrated by exhibiting core skills including:<br>(1) technical knowledge;<br>(2) cultural awareness;<br>(3) analytical skills;<br>(4) decision-making;<br>(5) interpersonal skills;<br>(6) communication skills; and<br>(7) clinical skills.<br>(e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based | V 109 | | |

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE    TITLE    (X6) DATE

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| V 109 | Continued From page 1<br>employment system in the State Plan for MH/DD/SAS.<br>(f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional.<br>(g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter.<br><br>This Rule is not met as evidenced by:<br>Based on record review, and interview the facility failed to ensure that 2 of 3 audited Qualified Professionals (Clinical Director, Registered Nurse #1) demonstrated knowledge, skills and abilities required by the population served. The findings are:<br><br>Record review on 6/26/18 for Former Client #4 (FC #4) revealed:<br>-Admitted on 4/28/18 with diagnoses of Stimulant Use Disorder, Bi-Polar Disorder, Anxiety Disorder, Attention Deficit Hyperactivity Disorder, and Hypertension.<br>-IVC (involuntary commitment) petition dated 4/27/18 indicated "chemically dependent since age 22 ...lives with mental health Disorder ...at this time present manic symptoms. This individual at this time is a danger to self as well as members of the household in which he resides with elderly parents ..."<br>-History of racing thoughts, inability to focus, use of cocaine and methamphetamine since age 22 and last use on 4/26/18 ..." | V 109 | | |

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| V 109 | Continued From page 2 | V 109 | | |

Review on 6/28/18 of the personnel record for Registered Nurse #1 (RN #1) revealed:
-Date of hire was 9/6/16.
-RN Permanent License valid through 4/30/20.
-BSN (Bachelor of Nursing) at a state University in 2016.

Review on 6/28/18 of the personnel record for the Clinical Director revealed:
-Date of hire was 6/10/13.
-Licensed Clinical Social Worker valid through 6/30/20.

Review on 6/26/18 of incident reports from 4/2018-6/2018 revealed:
-On 5/8/18 "During the 8p-8a shift on 5/7/18, consumer [FC #4] decompensated to the point of being sent out by EMS (emergency management services) at 0700 on 5/8/18. The consumer came to the medication window at 2100 to receive his bed time medications. They consisted of: Depakote ER 1500mg, Doxepin 100mg, Risperdal 3mg, and Trazadone 100mg. Consumer was alert, but some of his words were slurred. He slept a few hours, but then began coming out of his room with his clothes on backwards or in nothing but his underwear. The on call provider was called and she advised to send consumer to the ER (emergency room). Nursing staff then called [Clinical Director] and decision was made to wait until morning as it was felt that it would be unsafe to transport consumer and fear that hospital would only send him back. He would then go in and out of the restroom. He was responding to internal stimuli, as he was "picking" things from the air and acting as if he was completing a task. He was mumbling, but his words were incoherent. He would not open his eyes. Staff would re direct him back to his rom. He settled down until approximately 0430 at

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which time he came out of his room in his underwear. Nursing staff gave him 50mg Benadryl, 2mg Ativan, and 10mg Haldol at 0445. He went back to bed and rested but didn't sleep until 0700. At 0700 consumer was nonverbal, dystonic, would not open his eyes, and had an unsteady gait. While consumer was in his bed, he somehow hit his head on the wall. A 2.5 cm laceration was above his left eyebrow. It was not deep enough to bleed. EMS was called and consumer was transported to hospital ..."
-Incident report completed by the LPN (licensed practical nurse).

Review on 6/26/18 of the protocol for "Consumer Transfer for Medical Services" revealed:
-" ...Non-Emergency Medical Care ...The shift nurse shall contact the MD/NP (Medical Director/Nurse Practitioner) regarding the need for adjunct medical care and obtain a Verbal Order to facilitate transfer of the consumer ...The shift nurse shall ...assign a facility staff person to transport the consumer to the adjunct medical care service ..."
-"Emergency Medical Care ...The shift nurse shall call Emergency Medical Services or 911 to request emergency transport of the consumer to the adjunct medical care service...The shift nurse shall notify the MD/NP of the need for emergency medical treatment of the consumer ...Facility staff are not required to go with the consumer and EMS (emergency management services) to the adjunct medical care service ..."
-The protocol does not indicate any prolonged monitoring of the client prior to obtaining additional medical care.
-The protocol does not direct nursing staff to contact the Clinical Director.

Review on 6/27/18 of the Emergency Room

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Discharge summary dated 5/9/18 for FC #4 revealed:
-" ...presents the emergency department for altered mental status ...They (staff) stated that he had altered mental status early in the morning and has fallen several times ...according to staff he has fallen several times he has a bruise on his left forehead and right foot ...Head: Abrasion over his left forehead ..."
-"presenting with acute encephalopathy ...the patient is laying in bed and is unable to remain still. He kicks and thrashes about at times. He does not open his eyes. He has difficulty following commands ...the patient, although he is able to make verbal tones, does not make any verbal conversation ...X-ray of right foot shows fifth metatarsal fracture ...CT (cat scan) head unremarkable ...agitated ...dehydrated ...disoriented to person, place, time, and situation ..."
-" ...Acute encephalopathy has resolved. Agree with transferring patient to [behavioral health unit] ..."

Review on 6/27/18 of the "Physician's Standing Orders" revealed:
-The protocol when Haldol 5mg-10mg for psychosis is given is to " ...Notify MD/NP if given ..."
- The protocol when Ativan 1mg-2mg for severe agitation is given is to " ...Notify MD/NP if given ..."

Interview on 6/26/18 with the LPN (licensed practical nurse) revealed:
-She was a newly hired LPN and was training with Registered Nurse #1 (RN #1) the night of the incident.
-She stated that FC #4 was "fine" when medications were administered at 9:00PM. She

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indicated that his speech was "slurred but that was not out of the norm for him".
-She described the speech for FC #4 as "word salad, mumbling, and talked fast".
-She did not remember who actually called the on call Provider or at what time.
-She indicated that RN #1 called the Clinical Director who told him to wait until morning to send FC #4 to the hospital.
-She did not know why the decision was made to wait.
-FC #4 was psychotic and delusional and she would redirect him when he got out of bed.
-She stated that "you could tell something was going on". Additional medications were given to him and "he was worse", "incoherent".
-EMS (emergency management services) arrived around 6:30AM.

Interviews on 6/26/18 and 6/27/18 with RN #1 revealed:
-On 5/6/18, FC #4 had some confusion, slurred speech and "didn't know where he was". On 5/7/18 he assessed FC #4 as having a psychotic episode. The Physician's Assistant (PA) was on call and gave an order for FC #4 to be sent to the hospital.
-When interviewed about his contact with the PA on the night of the incident he first stated that the Physician's Assistant (PA) advised him that "if symptoms worsen you probably need to send him out."
-In a later interview he indicated that the LPN (Licensed Practical Nurse) had actually been the one who called the PA and the PA ordered for Former Client #4 (FC #4) to be sent to the ER. The LPN indicated that "[PA] said to send him (FC #4) out."
-He could not remember the time that the PA was contacted but indicated it was "way earlier" that

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| V 109 | Continued From page 6<br><br>night.<br>-He "didn't know what to do, didn't know whether to IVC (involuntary commitment) him or call the police." He stated that he "went ahead and called [Clinical Director]."<br>-He indicated that he contacted the Clinical Director to discuss the transportation for FC #4. He informed the Clinical Director that the PA wanted FC #4 sent to the ER.<br>-He stated that the Clinical Director said to "just watch him" and wait until the following morning when she and the Director got there and then they would determine what to do. He indicated that they "were fearful that the hospital would send him back".<br>-He did not follow the verbal order given by the PA for FC #4.<br>-He indicated that in the heat of the moment he did not consider the protocol for the transfer for medical services outside of the clinic.<br>-There was no discussion about calling for an ambulance earlier during the night.<br>-FC #4 was not sent to the hospital until the following morning.<br>-He administered a protocol for a combination of Haldol/Ativan/Benadryl for the psychosis but the medications didn't help. He stated that he attempted to call the medical provider about the medications that he had administered but never talked to the PA after the medications were given. He also indicated that he sent a text message to the Nurse Practitioner (NP). Neither contact had been documented.<br>-He stated that FC #4's behaviors got really bad the next morning. He described FC #4 as "catatonic".<br>-He stated that by the next morning FC #4 was "mute, blinking his eyes and jerking his head".<br>-They believed that when he was sitting in his bed the following morning he jerked his head and hit | V 109 | | |

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| V 109 | Continued From page 7<br>the wall resulting in a small laceration on his head.<br>-They had determined that his behaviors were most likely related to side effects of the medications.<br>-He indicated that the Executive Director advised him to call an ambulance when he came in the next morning.<br><br>Interview on 6/26/18 with the Clinical Director revealed:<br>-RN #1 called her the night of the incident and asked if they should send FC #4 to the hospital. She could not specify the time of the call.<br>-She advised RN #1 that it would not be good for one staff member to transport FC #4 by themselves and if they felt that he needed to go to the hospital then for them to call EMS (emergency management services). She further added that she advised them "if things escalated send him on".<br>-"I cannot remember if the nurse said she talked to the doctor."<br>-"I don't know why they waited."<br>-She had no contact with the on call medical provider that night.<br>-She indicated the protocol for emergencies is individualized. If a client had mental illness they may monitor the client for a while to see if behaviors increased.<br>-In some situations the doctor advised them to monitor the clients for a while and then send to the hospital.<br>-She said that normally she would say do what the doctor advised.<br>-"Directives from the physician should be followed."<br><br>Interviews on 6/25/18 and 6/27/18 with the Nursing Supervisor revealed: | V 109 | | |

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| V 109 | Continued From page 8<br>-Historically the hospital has asked that a staff member accompany a client that is sent there and she indicated that there have been times that the hospital would send them back to the clinic.<br>-On the night of the incident RN #1 was the only male staff working and was training the LPN. She indicated that RN #1 was unsure of how to handle the transportation.<br>-She stated that if the Nurse received an order and if they had questions or there was some reason the order could not be fulfilled the nurse should have called the MD/PA/NP back for direction.<br>-She was unaware of any follow up with the PA about the medical order for FC #4.<br>-EMS should have been called to transport FC #4 to the hospital.<br><br>Interview on 6/28/18 with the Executive Director revealed:<br>-When he arrived at the facility on the morning of 5/8/18 RN #1 informed him of what had occurred with FC #4.<br>-FC #4 was out of his room at that time. He observed FC #4 to have rigid movements, clammy skin, off balance and stumbling around, and was unable to open his eyes.<br>-He helped FC #4 get dressed and tried to check his eyes. FC #4's "eyes were rolled back in his head". There was a laceration on his forehead and they believed he fell against the wall. The laceration was superficial and not bleeding. He had no knowledge of FC #4 having injured his foot.<br>-He instructed RN #1 to call 911 immediately.<br>-He indicated when the on call medical provider issued an order, the order was to be followed. FC #4 should have been sent to the emergency room when the PA gave the order to RN #1. | V 109 | | |

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| V 109 | Continued From page 9<br>Interview on 6/27/18 with the PA (Physician's Assistant) revealed:<br>-She had been on call the night of 5/7/18.<br>-She could not recall any specifics of what had occurred with FC #4.<br>-She could not remember what time she talked to the nurses but indicated that she would have ordered him to go to the ER in an effort to have him further assessed to rule out any other medical problems or anytime she felt that a client may need a higher level of care.<br><br>Interview on 6/27/18 with the Medical Director revealed:<br>-FC #4 was diagnosed with a "dystonic reaction" which was not life threatening. She indicated that it was quite common and quickly treatable. Symptoms included tremors, jerking, and muscle spasms.<br>-Any anti-psychotic medication can cause the dystonic reaction. It was hard to predict who would have that kind of reaction to the medication. Haldol was a medication that could cause that reaction more often.<br>-FC #4 was prescribed Doxepin and Trazodone for sleep. These medications taken together can increase confusion. She further added that all of the medications that FC #4 took together could increase confusion.<br>-The protocol of Haldol, Benadryl, and Ativan given to FC #4 was not contraindicated. It was administered because he was so psychotic.<br>- The order given by the PA (physician's assistant) should have been followed. The expectation for all nurses was that they follow medical orders.<br>-She indicated that there usually was no problem with nursing staff following the orders.<br>-She stated that the reasons for waiting until morning were "not right" and she was concerned about medical orders not being followed. | V 109 | | |

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| V 109 | Continued From page 10<br>-When the NP (Nurse Practitioner) or PA sends a patient to the emergency room it was normally to determine if other medical problems were involved or when a patient showed signs of decline.<br>-"He should have been sent to the ER (emergency room)."<br><br>This deficiency is cross referenced into 10A NCAC 27G .5003 Operations (V271) for a Type A1 rule violation and must be corrected within 23 days. | V 109 | | |
| V 118 | 27G .0209 (C) Medication Requirements<br><br>10A NCAC 27G .0209 MEDICATION REQUIREMENTS<br>(c) Medication administration:<br>(1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs.<br>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.<br>(3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications.<br>(4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following:<br>(A) client's name;<br>(B) name, strength, and quantity of the drug;<br>(C) instructions for administering the drug;<br>(D) date and time the drug is administered; and | V 118 | | |

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| V 118 | Continued From page 11<br>(E) name or initials of person administering the drug.<br>(5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review and interviews the facility failed to ensure that all medications administered were ordered by a person authorized by law to prescribe drugs for 1 of 3 audited clients (#1). The findings are:<br><br>Observation on 6/25/18 at 11:00AM of the medications for Client #1 revealed:<br>-Trazodone (sedative and antidepressant) 100mg, dispensed on 6/19/18.<br>-Mirtazapine (antidepressant) 15mg, dispensed on 6/19/18.<br>-Sertraline (depression, obsessive-compulsive disorder, and post-traumatic stress disorder) 100mg, dispensed on 6/19/18.<br><br>Record review on 6/25/18 for Client #1 revealed:<br>-Admitted on 6/18/18 with diagnoses of alcohol abuse and severe Depressive Disorder.<br>-The physician orders for Trazodone 100mg, one at bedtime, Mirtazapine 15mg, one at bedtime, and Sertraline 100mg, one daily were given verbally to the nurse on 6/19/18. These orders had not yet been signed by the physician as of 6/25/18.<br><br>Review on 6/25/18 of the June 2018 MAR for Client #1 revealed: | V 118 | | |

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| | MHL023-171 | A. BUILDING: ______ B. WING ______ | 06/28/2018 |

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| CLEVELAND CRISIS AND RECOVERY CENTER | 609 NORTH WASHINGTON STREET SHELBY, NC 28150 |

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| V 118 | Continued From page 12<br>-Sertraline administered daily from 6/20/18-6/25/18 without a signed physician's order.<br>-Trazodone administered at bedtime from 6/19/18-6/24/18 without a signed physician's order.<br>-Mirtazapine administered at bedtime from 6/19/18-6/24/18 without a signed physician's order.<br><br>Interview on 6/26/18 with Registered Nurse #2 (RN #2) revealed:<br>-The Medical Director gave verbal orders for medications and signed orders twice per week.<br>-The Nurse Practitioner was in the facility on Thursday and Friday only and signed orders on those days.<br>-She indicated that there were times that signatures for orders were missed.<br>-She further indicated that at times verbal orders went beyond the 72 hour timeframe for signatures.<br>-There was no system in place for electronic signatures for medication orders.<br><br>Interview on 6/25/18 with the Nursing Supervisor revealed:<br>-The medication orders for Client #1 were overlooked.<br>-When the verbal orders were taken for Client #1's medications they were set aside for a signature at a later date. The orders were never signed. | V 118 | | |
| V 271 | 27G .5003 Facility Based Crisis - Operations<br><br>10A NCAC 27G .5003 OPERATIONS<br>(a) Each facility shall have protocols and procedures for assessment, treatment, | V 271 | | |

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| V 271 | Continued From page 13<br>monitoring, and discharge planning for adults and for children of each disability group served in the facility. Protocols and procedures shall be approved by the area program's medical director or the medical director's designee, as well as the director of the appropriate disability unit of the area program.<br>(b) Discharge Planning and Referral to Treatment/Rehabilitation Facility. Each facility shall complete a discharge plan for each client that summarizes the reason for admission, intervention provided, recommendations for follow-up, and referral to an outpatient or day program or residential treatment/rehabilitation facility.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interviews the facility failed to implement protocols and procedures for treatment for adults of each disability group served in the facility effecting 1 of 1 former clients audited (FC #4). The findings are:<br><br>Cross Reference: 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (V109). Based on record review, and interview the facility failed to ensure that 2 of 3 audited Qualified Professionals (Clinical Director, Registered Nurse #1) demonstrated knowledge, skills and abilities required by the population served.<br><br>Review on 6/28/18 of the Plan of Protection signed and dated on 6/28/18 by the Executive Director revealed:<br>What immediate action will the facility take to ensure the safety of the consumers in your care?<br>-"All staff will be notified immediately of the | V 271 | | |

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| V 271 | Continued From page 14<br><br>following:<br>-The nurse on duty will contact Emergency Medical Services (EMS) regarding any consumer in need of emergency medical care immediately. After EMS is contacted they will notify the provider of the situation, the hospital of the consumer's situation, and the RN supervisor.<br>-The nurse on duty will contact the medical provider of any non-emergent medical situation for orders, contact the hospital, and send the consumer.<br>-Staff will be available to escort/sit with consumer when required during all medical situations. If staff are not appropriate to escort/sit the nurse on duty will contact RN supervisor for further instructions and will update on-call provider. If RN supervisor is unavailable immediately contact provider for further instruction. If on call provider is unavailable immediately contact EMS for transport of consumer to the ED.<br>-Nurse on duty will document all interactions with supervisors and providers.<br>-RN supervisor will be available 24/7/365 for oversight and contact if needed.<br>-Protocols dealing with medical procedures will be reviewed immediately.<br>-At any time the nurse on duty has medical related questions they will contact the provider and if not immediately available they will contact the nursing supervisor.<br>-At no point will clinical director be contacted regarding emergency medical protocols and procedures.<br>-Facility director will be contacted to be advised of all situations if needed."<br><br>Describe your plans to make sure the above happens:<br>-"Email will be sent out of the above changes immediately following approval to all staff. | V 271 | | |

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| V 271 | Continued From page 15<br>-Copy of all changes will be presented to staff on duty and discussed immediately following approval.<br>-Clinical manager will consult with supervisor prior to making any clinical decisions impacting consumer care.<br>-Clinical manager will meet every morning with Facility Director daily to address clinical issues involving consumer care.<br>-RN supervisor will contact all nurses prior to next shift of all changes to ensure they know the changes.<br>-RN supervisor will ensure nurse on duty present knows and understands changes and will be given copy of all changes and will report these changes off to oncoming staff to ensure they know proper procedures.<br>-RN supervisor will provide oversight of nursing decisions made by the RN and will meet with him weekly to review nursing decisions.<br>-Training will be provided to all staff regarding medication side effects of medications administered to include when to report, how to report and to whom to report by July 13th.<br>ALL ABOVE ACTIONS ARE IN PROCESS NOW"<br><br>FC #4 had diagnoses of Bi-Polar Disorder and Anxiety Disorder exacerbated by chronic substance abuse for 17 years which most recently led to an involuntary commitment into the facility based crisis unit. On 5/7/18 FC #4 was exhibiting psychotic symptoms. The Physician's Assistant on call was contacted regarding the declining condition of FC #4 and ordered that he be sent to the hospital emergency room. RN #1 did not follow the order and instead contacted the Clinical Director who advised him to keep FC #4 at the facility until morning. The Clinical Director and RN #1 made the decision to wait based on staffing issues and hospital response not the | V 271 | | |

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| V 271 | Continued From page 16<br>health and safety needs of FC #4. FC #4 continued to deteriorate through the night and by morning had sustained a laceration on his forehead as a result of his unresponsive, dystonic condition. Upon examination at the hospital it was also discovered that he had a fractured metatarsal. These failures resulted in a Type A1 violation for serious neglect of FC #4 and must be corrected with 23 days. An administrative penalty in the amount of $3000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day. | V 271 | | |