Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMIT LETED
		MHL029-134	B. WING		C 11/09/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
DAVIDSO	N CRISIS CENTER		IAIN STREET N, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 000	INITIAL COMMENTS	1	V 000		
	The complaint was st #NC143406). Deficie This facility is license category: 10A NCAC 27G .500	•			
V 270	27G .5002 Facility Ba	ased Crisis - Staff	V 270		
	ratios that ensure the served in the facility. (b) Staff with training provision of care to the present at all times with the facility shall hadditional staff on site supervision, treatmer response to the need (d) The treatment of the supervision of a part of the supervision of	I maintain staff to client health and safety of clients I and experience in the he needs of clients shall be then clients are in the facility. have the capacity to bring to to provide more intensive ht, or management in s of individual clients. each client shall be under thysician, and a physician 24-hour per day basis. staff member shall have qualified professionals who sability area(s) of the clients to working. Staff member shall be trained ledge about mental illnesses dications and their side			

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

(X6) DATE TITLE

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
						С
		MHL029-134	B. WING		11	/ <mark>09/2018</mark>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
DAVIDSO	DAVIDSON CRISIS CENTER 1104 B S MAIN STREET					
		LEXING	TON, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
V 270	Continued From page	e 1	V 270			
	client's needs.					
	This Rule is not met	as evidenced by:				
		ews and interviews, the				
		e each direct care staff was				
	-	knowledge about mental				
	illnesses and psychot	ropic medications and their				
	side effects; mental re	etardation and other				
	•	lities and accompanying				
		of addiction and recovery				
	•	vndrome; and treatment				
	_	ults and children in crisis.				
	The findings are:					
	Review on 11/0/18 of	the facility's contract with a				
	Staffing Agency revea					
		ed into a contract with the				
	Staffing Agency on 2/					
	"supplemental clinica					
	personnel" to the faci	lity;				
		ency] agrees that it shall				
	·	emental Staff provided to				
		ar with Facility policies,				
		on, Facility protocols and				
		s of care. However, any				
		Supplemental Staff shall be				
	the Facility's responsi	specify that Supplemental				
		aining in mental illnesses				
		dications and their side				
	effects; mental retard					
		lities and accompanying				
		of addiction and recovery				
		ndrome; and treatment				
		ults and children in crisis.				
	Daview on 11/9/19 of	the facility's staffing				
	Review on 11/8/18 of schedules from 8/1/18	the facility's staffing 8 to 10/31/18 revealed:				

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STATE FORM STS711 If continuation sheet 2 of 16

Division of Health Service Regulation

DIVISION	of Health Service Regu	liation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
		MHL029-134	B. WING		C	9/2018
		WITIL029-134			11/0	9/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		1104 B S	MAIN STREET			
DAVIDSOI	N CRISIS CENTER		ON, NC 27292			
	CUMMA DV CT	ATEMENT OF DEFICIENCIES		DDOVIDEDIC DI ANI OF CODDECTIO	N	
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
V 270	Continued From page	2	V 270			
V 210	Continued From page	5 2	V 270			
	- Supplemental Staff	Nurses worked at the facility				
	on 14 of 31 days in A	ugust, 11 of 30 days in				
	September and 15 of	31 days in October.				
	Review on 11/9/18 of	the Staffing Agency's				
	employee training for	ms revealed:				
	 Two "Acknowledger 	ment Form; [Accreditation				
		ducational In-Services"				
	forms were used to tr	ack trainings completed by				
	Staffing Agency Supp	olemental Staff;				
	- The form for " Sec	ction A: Staffing Agency Core				
	Topics" included gene	eral trainings such as hand				
	hygiene, fire safety, d	lrug abuse policies &				
	procedures, and clinic	cal documentation;				
	- The form for " Se	ction B: Facility Core Topics"				
	included additional tra	ainings such as AMBER				
	Alerts, Communication	on with Limited English				
	Proficiency, Meal Bre	aks & Rest Periods, and				
	Occurrence & Claim I	Reporting;				
	- There were no traini	ings related to mental				
		tropic medications and their				
	side effects; mental re					
	developmental disabi	lities and accompanying				
		of addiction and recovery				
	,	yndrome; and treatment				
	methodologies for ad	ults and children in crisis.				
		with the Licensed Practical				
	Nurse (LPN) revealed					
	- She had worked at t					
		lurse through the Staffing				
		018 until she was hired by				
	the facility approxima					
		provided Supplemental				
		ntaining information about				
	• .	Supplemental Staff working				
	at the facility;					
		Staff begin working at the				
	facility, they are provi	ded with additional				
	information;					

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STATE FORM STS711 If continuation sheet 3 of 16

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(V2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION	
			A. BUILDING: _		
					С
		MHL029-134	B. WING		11/09/2018
NAME OF D	DOVIDED OD CLIDDLIED	CTDEETAN	DDECC CITY CTA	TE 710 000E	
NAIVIE OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	II E, ZIP GODE	
DAVIDSO	N CRISIS CENTER		MAIN STREET		
	ı	LEXINGI	ON, NC 27292		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	
IAO		,	IAG	DEFICIENCY)	
1/070	0 " 15		1/ 070		
V 270	Continued From page	2 3	V 270		
	- The facility provided	Supplemental Staff from			
	the Staffing Agency w	vith orientation information			
	related to cultural dive				
		conomic status, victims of			
	domestic violence, se	xual orientation and/or			
		nd other related information.			
	,				
	Interview on 11/9/18 v	with the Staffing Agency			
	Director of Nursing (S	SADON) revealed:			
		ot aware of the specific			
	trainings required by	licensure rule for each direct			
	care staff that worked	at the facility;			
	- The Staffing Agency	did provide training to			
	nurses before they we	orked at the facility, but it did			
	not include mental illr				
	medications and their	side effects, mental			
	retardation and other	developmental disabilities			
	and accompanying be	ehaviors, the nature of			
	addiction and recover	ry and the withdrawal			
	syndrome, or treatme	nt methodologies for adults			
	and children in crisis;				
	- Supplemental Staff	did get training on the use of			
	Librium in detox, but i	not other psychotropic			
	medications;				
	- Some of the Supple	mental Staff that the Staffing			
	Agency sent to the fa	cility had worked in similar			
	environments, and the	ey were utilized as much as			
	possible when the fac	cility needed staff.			
		with the Program Director			
	(PD) revealed:				
	- The PD did not have				
		om the Staffing Agency;			
		ADON when the facility			
		ver a shift at the facility;			
		then arranged for a nurse			
	to work at the facility;				
		e Staffing Agency was			
		he Licensee's Human			
	Resources (HR) Depa	artment;			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _			
		MHL029-134	B. WING		C 11/09/2018	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DAVIDSOI	N CDICIC CENTED	1104 B S M	AIN STREET			
DAVIDSOI	N CRISIS CENTER	LEXINGTO	N, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 270	Continued From page	e 4	V 270			
	- HR may have worker for Supplemental State Interviews on 11/8/18 Based Crisis Operation revealed: - The facility contracter for nursing staff to convast unable to fill with - The Staffing Agency necessary trainings to before they were sent	ed out the details of training ff from the Staffing Agency. and 11/9/18 with the Facility ons Director (FBCOD) ed with the Staffing Agency over shifts in which the facility their own nursing staff; was supposed to provide o Supplemental Staff nurses t to the facility to work; whad a checklist of trainings				
V 536	27E .0107 Client Right Int.	nts - Training on Alt to Rest.	V 536			
	to restrictive intervent (b) Prior to providing disabilities, staff inclue employees, students demonstrate compete completing training in other strategies for cr which the likelihood or injury to a person verification property damage is proceed to provide agencies based on state compete compliance and demonstrate.	plement policies and size the use of alternatives ions. services to people with ding service providers, or volunteers, shall ence by successfully communication skills and eating an environment in fimminent danger of abuse with disabilities or others or revented. s shall establish training etencies, monitor for internal constrate they acted on data				

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DIVISION	of Health Service Regu	lation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			_		
					C
		MHL029-134	B. WING		11/09/2018
			•		
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
D 41///D001	I ODIOIO OENTED	1104 B S	MAIN STREET		
DAVIDSOI	N CRISIS CENTER	LEXINGT	ON, NC 27292		
	CUMMADY CT			DROVIDERIC DI ANI OF CORRECTION	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	· - /
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		,		DEFICIENCY)	
V 536	Continued From page	e 5	V 536		
		vritten and by observation of			
	· ·	ejectives and measurable			
	methods to determine	e passing or failing the			
	course.				
	(e) Formal refresher	training must be completed			
	• •	der periodically (minimum			
	annually).	der perredicany (minimani			
	• •	ining that the convice			
	(f) Content of the trai				
		nploy must be approved by			
	the Division of MH/DE	•			
	Paragraph (g) of this	Rule.			
	(g) Staff shall demon	strate competence in the			
	following core areas:				
	•	and understanding of the			
	people being served;				
	•	and interpreting human			
	behavior;	and interpreting numan			
	•	the effect of internal and			
		the effect of internal and			
		at may affect people with			
	disabilities;				
		or building positive			
	relationships with per-	sons with disabilities;			
	(5) recognizing	cultural, environmental and			
	organizational factors	that may affect people with			
	disabilities:				
	(6) recognizing	the importance of and			
		n's involvement in making			
	decisions about their				
		essing individual risk for			
		essing individual risk for			
	escalating behavior;	tion of the total of the state			
		tion strategies for defusing	1		
	• •	tentially dangerous behavior;			
	and				
	(9) positive beh	navioral supports (providing			
	means for people with	h disabilities to choose			
	activities which direct				
	behaviors which are u				
	(h) Service providers				
		al and refresher training for			
	accumentation of Itili	ai and refresher trailing to	1		

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Division of	<u>of Health Service Regu</u>	ilation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		MIII 000 404	B. WING		C
		MHL029-134] 5:		11/09/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		1104 B S I	MAIN STREET		
DAVIDSOI	N CRISIS CENTER	LEXINGTO	ON, NC 27292		
(V4) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	J (VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	(/
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	NATE DATE
				DEFICIENCY)	
V 536	Continued From page	2.6	V 536		
V 000	Continued From page	5 0	* 000		
	at least three years.				
	(1) Documenta	ition shall include:			
	(A) who particip	ated in the training and the			
	outcomes (pass/fail);	-			
		where they attended; and			
	(C) instructor's	name;			
		n of MH/DD/SAS may			
		ocumentation at any time.			
	(i) Instructor Qualification	_			
	Requirements:	eneric ente in enimig			
	•	all demonstrate competence			
		esting in a training program			
	-	reducing and eliminating the			
	need for restrictive in	•			
		all demonstrate competence			
		grade on testing in an			
		-			
	instructor training pro (3) The training				
	` '	-			
		nclude measurable learning ble testing (written and by			
		ior) on those objectives and			
		to determine passing or			
	failing the course.	t of the inetructor training the			
		t of the instructor training the			
	service provider plans				
		sion of MH/DD/SAS pursuant			
	to Subparagraph (i)(5				
		instructor training programs			
		not limited to presentation of:			
		ng the adult learner;			
		r teaching content of the			
	course;				
	` '	r evaluating trainee			
	performance; and				
		tion procedures.			
		all have coached experience			
	teaching a training pr	ogram aimed at preventing,			
	reducing and eliminat	ting the need for restrictive			
	_	one time with positive	1		

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Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL029-134 B. WING			C 11/09/2018	
	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA Main Street Dn, NC 27292	TE, ZIP CODE	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 536	aimed at preventing, need for restrictive in annually. (8) Trainers shainstructor training at legislation of initial training for at least the (1) Docume (A) who participoutcomes (pass/fail); (B) when and verification of the course and review the (C) instructor's (2) The Division request and review the (K) Qualifications of (C) Coaches share (C) Coaches share course which is be (C) Coaches share course which is be (C) Coaches share course which is be (C) Coaches share (C) C) Coaches (C) C) Coaches (C) C) Coaches (C) C) C	all teach a training program reducing and eliminating the terventions at least once all complete a refresher east every two years. shall maintain ial and refresher instructor ree years. entation shall include: anted in the training and the where attended; and name. In of MH/DD/SAS may his documentation any time. Coaches: hall meet all preparation iner. In all teach at least three times eing coached. In all demonstrate oletion of coaching or	V 536			
	facility failed to ensur training on alternative	as evidenced by: ews and interviews, the e service providers received es to restrictive interventions vices to clients. The findings				

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STATE FORM STS711 If continuation sheet 8 of 16

Division of Health Service Regulation

Division o	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPI	LETED
						0
		MUU 000 404	B. WING		I	C
		MHL029-134			11/0	09/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		1104 B S	MAIN STREET			
DAVIDSO	N CRISIS CENTER	LEXING ⁷	TON, NC 27292			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE		(X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APP	PROPRIATE	DATE
				DEFICIENCY)		
V 536	Continued From page	<u> </u>	V 536			
		, 0	1 222			
		the facility's contract with a				
	Staffing Agency revea					
		ed into a contract with the				
	Staffing Agency on 2/					
	"supplemental clinical					
	personnel" to the faci					
		jency] agrees that it shall				
		emental Staff provided to				
		iar with Facility policies,				
		ion, Facility protocols and				
		s of care. However, any				
		Supplemental Staff shall be				
	the Facility's responsi					
		specify that Supplemental				
		aining on alternatives to				
	restrictive intervention	15.				
	Daviou on 11/9/19 of	the facility's staffing				
	Review on 11/8/18 of	8 to 10/31/18 revealed:				
		Nurses worked at the facility				
		ugust, 11 of 30 days in				
	September and 15 of	•				
		or days in October.				
	Review on 11/9/18 of	the Staffing Agency's				
	employee training for	0 0 ,				
	- No training on altern					
		ovided to Supplemental Staff.				
	Interview on 11/7/18 v	with the Licensed Practical				
	Nurse (LPN) revealed	d:				
	- She had worked at t					
	Supplemental Staff N	urse through the Staffing				
		018 until she was hired by				
	the facility approxima					
		of the Staffing Agency, she				
		ning on alternatives to				
	restrictive intervention	ns;				
	- Once she was hired	by the facility, she did				

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receive training on alternatives to restrictive

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DIVISION	i Health Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
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	MHL029-134 B. WING			1		
		WITL029-134			1 11/0	9/2018
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		1104 B S I	MAIN STREET			
DAVIDSO	N CRISIS CENTER	LEXINGTO	ON, NC 27292			
(V4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES	ı,	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI	RIATE	DATE
				DEFICIENCY)		
V 536	Continued From page	2 Q	V 536			
	. •					
	interventions as part	of her orientation.				
	Interview on 11/0/10	with the Ctoffing Agency				
	Director of Nursing (S	with the Staffing Agency				
		ot aware that training on				
	alternatives to restrict	_				
		e providers prior to working				
	with clients:	o providere prier to werking				
	· ·	did provide training to				
		orked at the facility, but it did				
	-	alternatives to restrictive				
	interventions.					
	Interview on 11/9/18 v	with the Program Director				
	(PD) revealed:					
		e Staffing Agency was				
	•	he Licensee's Human				
	Resources (HR) Depa					
	•	ed out the details of training				
		trictive interventions for				
		om the Staffing Agency;				
	- The PD did not have	•				
	• •	om the Staffing Agency had				
	received required train	nings.				
	Interviews on 11/8/18	and 11/9/18 with the Facility				
		ons Director (FBCOD)				
	revealed:	(= 302)				
	- The facility contracte	ed with the Staffing Agency				
		ver shifts in which the facility				
		their own nursing staff;				
		was supposed to provide				
		Supplemental Staff nurses				
	, ,	t to the facility to work;				
		had a checklist of trainings				
	that they provided to					
	- The facility did not p	rovide Supplemental Staff				
	from the Staffing Age					
	alternatives to restrict	ive interventions.				

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Division of	<u>of Health Service Regu</u>	ılation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					С	
		MHL029-134	B. WING		11/09/2018	
					11/00/2010	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
DAVIDSOL	DAVIDSON CRISIS CENTER 1104 B S					
DAVIDOO	TORIOIO OENTER	LEXING	ON, NC 27292			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	(*)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		
IAG	REGOLATORY OF	LOG IDENTIFICATION OF WILL ATTEMPT	IAG	DEFICIENCY)	W. (1)	
V 537	Continued From page	e 10	V 537			
V 537	27E 0109 Client Diel	nts - Training in Sec Rest &	V 537			
V 331	ITO	ilis - Hailling III Sec Rest &	V 337			
	110					
	10A NCAC 27E .0108	B TRAINING IN				
		CAL RESTRAINT AND				
	ISOLATION TIME-OU					
		cal restraint and isolation				
		loyed only by staff who have				
	been trained and hav					
		oper use of and alternatives				
		Facilities shall ensure that				
		ploy and terminate these				
		ned and have demonstrated				
	competence at least	annually.				
	(b) Prior to providing	direct care to people with				
	disabilities whose trea	atment/habilitation plan				
	includes restrictive in	terventions, staff including				
	service providers, em					
		olete training in the use of				
		estraint and isolation time-out				
		se interventions until the				
	training is completed	and competence is				
	demonstrated.	a 4 a Liba ar Alaira Amarinina ar in				
		r taking this training is				
	• .	etence by completion of				
		, reducing and eliminating				
	the need for restrictiv	be competency-based,				
	include measurable le					
		written and by observation of				
		pjectives and measurable				
	•	e passing or failing the				
	course.					
		training must be completed				
		der periodically (minimum				
	annually).					
	(f) Content of the train	ining that the service				
		ploy must be approved by				
	the Division of MH/DI					

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DIVISION	n nealth Service Regu	ialion	_		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			B. WING		С
		MHL029-134	B. WING		11/09/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZIP CODE	
				,	
DAVIDSOI	N CRISIS CENTER		MAIN STREET		
		LEXINGI	ON, NC 27292		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	(- /
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORT OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIAIE
V 537	Continued From page	e 11	V 537		
	. •				
	Paragraph (g) of this				
		ng programs shall include,			
	but are not limited to,	presentation of:			
	(1) refresher inf	formation on alternatives to			
	the use of restrictive i	nterventions;			
	(2) guidelines o	on when to intervene			
		ent danger to self and			
	others);	Ü			
		n safety and respect for the			
	. ,	Ill persons involved (using			
		rictive interventions and			
	incremental steps in a				
		•			
		or the safe implementation			
	of restrictive intervent				
		mergency safety			
	interventions which in				
		itoring of the physical and			
		ing of the client and the safe			
	use of restraint through	ghout the duration of the			
	restrictive intervention	า;			
	(6) prohibited p	rocedures;			
	(7) debriefing s	trategies, including their			
	importance and purpo	ose; and			
		tion methods/procedures.	1		
	(h) Service providers	•			
	•	al and refresher training for	1		
	at least three years.				
		tion shall include:			
	. ,	ated in the training and the			
		ated in the training and the			
	outcomes (pass/fail);	whore they ettended; and	1		
		where they attended; and			
	(C) instructor's				
	• •	n of MH/DD/SAS may			
		ocumentation at any time.	1		
	(i) Instructor Qualification	ation and Training			
	Requirements:				
	(1) Trainers sha	all demonstrate competence			
	by scoring 100% on to	esting in a training program			
		reducing and eliminating the			

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Division of Health Service Regulation

DIVISION C	Division of Health Service Regulation						
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDE		IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED		
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MHL029-134		B. WING					
		WITL029-134			11/09/2018		
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
		1104 B S	MAIN STREET				
DAVIDSO	N CRISIS CENTER		ON, NC 27292				
	OLIMANA DV OT			DDOLUBERIO PLANTOS CORRECTIO	.,		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	(-1-)		
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				DEFICIENCY)			
V 537	Continued From none	- 10	V 537				
V 331	Continued From page	E 12	V 337				
	need for restrictive in	terventions.					
	(2) Trainers sha	all demonstrate competence					
	by scoring 100% on t	esting in a training program					
	teaching the use of se	eclusion, physical restraint					
	and isolation time-out						
	(3) Trainers sha	all demonstrate competence					
		grade on testing in an					
	instructor training pro	-					
	(4) The training						
		nclude measurable learning					
		le testing (written and by					
	•	ior) on those objectives and					
		to determine passing or					
	failing the course.	to dotoo padog c.					
	~	t of the instructor training the					
	service provider plans	_					
		sion of MH/DD/SAS pursuant					
	to Subparagraph (j)(6	-					
	(6) Acceptable instructor training programs shall include, but not be limited to, presentation						
	of:	be inflicted to, procentation					
		ng the adult learner;					
		r teaching content of the					
	course;	. todoming dontone or the					
		of trainee performance: and					
		ion procedures.					
		all be retrained at least					
	` '	strate competence in the use					
		restraint and isolation					
		in Paragraph (a) of this					
	Rule.	i ii i aiagiapii (a) 0i iiiis					
		all be currently trained in					
	CPR.	an be curreinly halfied in					
		all have coached experience					
		all have coached experience					
	•	f restrictive interventions at					
		positive review by the					
	coach.	all tagala a parameter (
		all teach a program on the					
	use of restrictive inter	rventions at least once	1				

Division of Health Service Regulation

STATE FORM STS711 If continuation sheet 13 of 16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING DAVIDSON CRISIS CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1104 B S MAIN STREET LEXINGTON, NC 27292 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 537 Continued From page 13 (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETE COMPLETE COMPLETE DATE (EACH CORRECTION SHOULD BE COMPLETE DATE OMPLETE DATE	Division of Health Service Regulation							
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1104 B S MAIN STREET LEXINGTON, NC 27292 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) V 537 Continued From page 13 A. BOILDING: B. WING C 11/09/2018 C 11/09/2018 O PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE			(X2) MULTIPLE	CONSTRUCTION				
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1104 B S MAIN STREET LEXINGTON, NC 27292 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 537 Continued From page 13 STREET ADDRESS, CITY, STATE, ZIP CODE 1104 B S MAIN STREET LEXINGTON, NC 27292 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DATE V 537 V 537						C		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1104 B S MAIN STREET LEXINGTON, NC 27292 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) V 537 Continued From page 13 STREET ADDRESS, CITY, STATE, ZIP CODE 1104 B S MAIN STREET LEXINGTON, NC 27292 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE V 537 V 537			MHL029-134	B. WING				
DAVIDSON CRISIS CENTER 1104 B S MAIN STREET LEXINGTON, NC 27292 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 537 Continued From page 13 1104 B S MAIN STREET LEXINGTON, NC 27292 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE V 537	NAME OF F		OTDEET A	DDDEGG OITY OTA	TE 710 000E	•		
DAVIDSON CRISIS CENTER LEXINGTON, NC 27292 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) V 537 Continued From page 13 LEXINGTON, NC 27292 ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE) COMPLETE DATE V 537	NAME OF P	ROVIDER OR SUPPLIER			TE, ZIP CODE			
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 537 Continued From page 13 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE) V 537 Continued From page 13 V 537	DAVIDSO	N CRISIS CENTER						
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 537 Continued From page 13 V 537 (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE V 537		T		ION, NC 27292				
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V 537 Continued From page 13 V 537						(- /		
V 537 Continued From page 13 V 537		,			CROSS-REFERENCED TO THE APPROPR			
					DEFICIENCY)			
	V 537	Continued From page 13		V 537				
annually.			- II					
(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			ated in the training and the					
outcome (pass/fail);		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		competence by comp	letion of coaching or					
train-the-trainer instruction.								
(m) Documentation shall be the same		, ,						
preparation as for trainers.		preparation as for train	ners.					
This Rule is not met as evidenced by:		This Rule is not met	as evidenced by:					
Based on record reviews and interviews, the			_					
facility failed to ensure service providers								
completed training in seclusion, physical restraint		_						
and isolation time out prior to providing services.								
The findings are:		The findings are:						
			n 6 99 1 2 2 2 2					
Review on 11/9/18 of the facility's contract with a								
Staffing Agency revealed: The Liganopa entered into a contract with the								
- The Licensee entered into a contract with the								
Staffing Agency on 2/7/17 to provide "supplemental clinical and administrative								

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personnel" to the facility;

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7. BOILDING.		c	
		MHL029-134	B. WING		11/09/2018	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
DAVIDSOI	N CRISIS CENTER		MAIN STREET			
		LEXINGT	ON, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 537	Continued From page 14		V 537			
	- " [The Staffing Agensure that all Supple Facility are fully famili Facility's job descripti established standards onsite orientation of Sthe Facility's responsition - The contract did not Staff would receive the restraint and isolation Review on 11/8/18 of schedules from 8/1/13 - Supplemental Staff on 14 of 31 days in A September and 15 of	ency] agrees that it shall emental Staff provided to far with Facility policies, on, Facility protocols and so of care. However, any Supplemental Staff shall be sibility" Is specify that Supplemental aining in seclusion, physical itime out. The facility's staffing 8 to 10/31/18 revealed: Nurses worked at the facility ugust, 11 of 30 days in 31 days in October. The Staffing Agency's				
	_	sion, physical restraint and s provided to Supplemental				
	Nurse (LPN) revealed - She had worked at the Supplemental Staff N Agency since April 20 the facility approxima - While an employee had not received train restraint and isolation - Once she was hired receive training in second isolation time out	the facility as a urse through the Staffing 118 until she was hired by tely one month ago; of the Staffing Agency, she ning in seclusion, physical time out by the facility, she did clusion, physical restraint as part of her orientation.				
		SADON) revealed: ot aware that training in estraint and isolation time out				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED	
	MHL029-134	B. WING		C 11/09/2018	
MHL029-134		<u> </u>		11/03/2010	
NAME OF PROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
DAVIDSON CRISIS CENTER		MAIN STREET			
		ON, NC 27292			
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
V 537 Continued From pa	Continued From page 15				
was required for all working with clients - The Staffing Ager nurses before they not include training and isolation time of line of the contract with coordinated throug Resources (HR) Douglar - The contract with coordinated throug Resources (HR) Douglar - The PD did not has supplemental Staff received required to linterviews on 11/8/ Based Crisis Operate revealed: - The facility contrate for nursing staff to was unable to fill working the staffing Ager that they provided to the Staffing Ager that they provided to fill working Ager that they provided to the Staffing Ager that they provided to fill working Ager that they provided to the Staffing Ager that Staffing Ager th	service providers prior to s; cy did provide training to worked at the facility, but it did in seclusion, physical restraint but. 8 with the Program Director the Staffing Agency was h the Licensee's Human epartment; ked out the details of training real restraint and isolation time al Staff from the Staffing ave a role in ensuring from the Staffing Agency had				

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