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
	MHL011-421	A. BUILDING: _____ B. WING _____	01/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAIYALYNN BURRELL CHILD CRISIS CENTER	277 BILTMORE AVENUE ASHEVILLE, NC 28801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual survey was completed on January 16, 2019. Deficiencies were cited. This facility is licensed for the following service categories: 10A NCAC 27G .3100 Nonhospital Medical Detoxification for Individuals who are Substance Abusers and 10A NCAC 27G .5000 Facility Based Crisis Service for Individuals of All Disability Groups.	V 000	DHSR - Mental Health FEB 18 2019 Lic. & Cert. Section	
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112	Assessment/Treatment/Habilitation Plan (Basic PCP) was revised on 1/24/19 to include: 1) Client outcomes that are anticipated to be achieved and a projected date of achievement 2) Strategies 3) Staff Responsible 4) Schedule for review of plan 5) Basis for evaluation or assessment of outcome achievement 6) Written consent or agreement by the client or responsible party, or a written statement by the provider stating why such a consent could not be obtained. The revised plan was put into place effective 1/24/19. All staff involved in the development of this plan were educated on the revised plan. Chart audits are completed nightly by a Registered Nurse to make sure the plan is completed correctly and obtains all pertinent signatures. Case management and licensed clinicians access this plan daily when meeting with clients.	

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to develop strategies for the treatment goals of 4 of 4 audited clients (#1, #2, #3, #4). The findings are: Record review on 1/15/19 for Client #1 revealed: -Admitted on 12/29/18 with diagnoses of Adjustment Disorder with mixed anxiety, and Depressed Mood Disorder. Review on 1/15/19 of the treatment plan for Client #1 revealed: -Treatment goals identified as work to better relationship with family (i.e. identify triggers and stressors within the family, explore and practice healthy coping skills for conflict resolution, develop safety plan) and to increase self-regulation skills (i.e. ability to identify and explain triggers and to increase the ability to communicate frustration and anger). -There were no identified interventions specified in the plan to address each goal. Record review on 1/15/19 for Client #2 revealed: -Admitted on 12/30/18 with diagnoses of Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, Intermittent Explosive Disorder, and Disruptive Mood Dysregulation. Review on 1/15/19 of the treatment plan for Client #2 revealed: -Treatment goals identified as development of 2-3 new self-soothing techniques, use of coping skills when escalating and to follow rules and requirements.	V 112		

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V 112	Continued From page 2 -There were no identified interventions specified in the plan to address each goal. Record review on 1/15/19 for Client #3 revealed: -Admitted on 1/9/19 with diagnoses of Cannabis Use Disorder, Attention Deficit Hyperactivity Disorder, and parent-child relational problem. Review on 1/15/19 of the treatment plan for Client #3 revealed: -Treatment goals identified as to work on coping skills three times per day, increase the level of communication (i.e. decreasing anger and blaming, increase level of responsibility, and to improve listening), and to decrease the risk for substance abuse (i.e. elimination of any substance use, increase level of honesty, and to decrease the involvement in the drug culture). -There were no identified interventions specified in the plan to address each goal. Record review on 1/16/19 for Client #4 revealed: -Admitted on 1/11/19 with diagnosis of Major Depressive Disorder, recurrent episode, severe. Review on 1/16/19 of the treatment plan for Client #4 revealed: -Treatment goals identified as to identify what triggers the substance use, communication of triggers, and express emotions (i.e. communicate depression in constructive manner, talk to staff, participate in groups, and deep breathing). -There were no identified interventions specified in the plan to address each goal. Interview on 1/16/19 with Counselor #1 revealed: -Counselors completed treatment plans as did the case managers. -They wanted the goals of the treatment plan to	V 112		

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V 112	Continued From page 3 be individualized and measureable. -She was not aware that specific interventions were required for each specific goal. -The Psychiatric Technicians used different strategies and interventions daily in treatment. Those interventions were specified in daily progress notes.	V 112		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable:	V 113	Client Records: The "Consent for Voluntary Admission to Caiyalynn Burrell Child Crisis Center" has been revised to include the statement, "I authorize FPS to seek emergency care from a hospital/physician for my child." This form was put into place on 1/18/19. All staff were educated on the revised form. Chart audits are completed nightly by a Registered Nurse to verify the consent is completed correctly and that it contains the signature of the parent/guardian.	

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V 113	Continued From page 4 (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to have a signed statement of permission to seek emergency medical care for 4 of 4 audited clients (#1, #2, #3, #4). The findings are: Record review on 1/15/19 for Client #1 revealed: -Admitted on 12/29/18 with diagnoses of Adjustment Disorder with mixed anxiety, and Depressed Mood Disorder. -No signed document giving the facility permission to seek emergency medical care. Record review on 1/15/19 for Client #2 revealed: -Admitted on 12/30/18 with diagnoses of Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, Intermittent Explosive Disorder, and Disruptive Mood Dysregulation. -No signed document giving the facility permission to seek emergency medical care. Record review on 1/15/19 for Client #3 revealed: -Admitted on 1/9/19 with diagnoses of Cannabis	V 113		

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V 113	Continued From page 5 Use Disorder, Attention Deficit Hyperactivity Disorder, and parent-child relational problem. -No signed document giving the facility permission to seek emergency medical care. Record review on 1/16/19 for Client #4 revealed: -Admitted on 1/11/19 with diagnosis of Major Depressive Disorder, recurrent episode, severe. -No signed document giving the facility permission to seek emergency medical care. Interview on 1/16/19 with the Director revealed: -The consent for emergency medical care should have been part of the "Consent for Voluntary Admission to the Caiyalynn Burrell Child Crisis Center" form completed at admission. -The emergency consent had been omitted which was an oversight. -She would add immediately.	V 113		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use.	V 114	Emergency Plans and Supplies: A new Safety Coordinator has been trained on all drills and procedures effective 1/18/19. Fire drills will be conducted monthly, alternating between day shift and night shift each month. The Director will check the drill logs before the end of each quarter to ensure all drills have been completed for the quarter.	

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V 114	Continued From page 6 This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to complete fire and disaster drills quarterly on each shift. The findings are: Review on 1/16/19 of fire and disaster drill documentation for July 2018 through December 2018 revealed: -No fire drills conducted on the night shift for the third (July-September) and fourth quarter (October-December). -No disaster drill conducted on the day shift for the third quarter. Interview on 1/16/19 with the Director revealed: -Personnel changes had occurred specific to who was responsible for safety drills. -They were unable to locate the paperwork for the missing drills. -She was unaware that drills were missing.	V 114		
V 220	27G .3103 Nonhospital Med. Detox. - Operations 10A NCAC 27G .3103 OPERATIONS (a) Monitoring Clients. Each facility shall have a written policy that requires: (1) procedures for monitoring each client's general condition and vital signs during at least the first 72 hours of the detoxification process; and (2) procedures for monitoring and recording each client's pulse rate, blood pressure and temperature at least every four hours for the first 24 hours and at least three times daily thereafter. (b) Discharge Planning And Referral To	V 220	Nonhospital Med. Detox. – Operations: The Vitals and Shift Assessment for was revised on 1/18/19 to state, "Vital signs are taken on admission and every 4 hours for the first 24 hours. After the first 24 hours, vital signs are taken three times daily." This form was put into effect on 1/18/19. All nursing staff were educated of the necessitated process. A vital sign book has been developed to place the "every 4 hour" checks at the front of the notebook. Chart audits are completed nightly by a Registered Nurse to verify vital signs have been completed as required.	

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V 220	Continued From page 7 Treatment/Rehabilitation Facility. Before discharging the client, the facility shall complete a discharge plan for each client and refer each client who has completed detoxification to an outpatient or residential treatment/rehabilitation facility. This Rule is not met as evidenced by: Based on record review and interview the facility failed to monitor and record vital signs every four hours for the first 24 hours and at least three times per day thereafter for 1 of 4 clients audited (#4). The findings are: Record review on 1/16/19 for Client #4 revealed: -Admitted on 1/11/19 with diagnosis of Major Depressive Disorder, recurrent episode, severe. -Admission note indicated that Client #4 was admitted for "detox from meth". -The "Physician's Admission Order Sheet" indicated that vital signs were to be checked "q (every) 4h (hours) x 24, then q shift." Review on 1/16/19 of the "Shift Assessment Form" for Client #4 revealed: -Temperature, pulse rate, respirations, blood pressure and general condition were monitored once daily. Interview on 1/15/19 with Client #4 revealed: -The first day they checked on her when she was in her room. She did not know how often. -Staff checked her vitals every morning. Interview on 1/6/19 with the Registered Nurse (RN) revealed:	V 220		

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V 220	Continued From page 8 -All clients were monitored every 4 hours during the first 24 hours. Vitals were checked and their neurological condition. -Staff did not awaken the clients when they were asleep to check vitals. Interview on 1/16/19 with the Director revealed: -Initially vitals were monitored three times per day then their physician said they only needed to check vitals once daily. Since that time they have checked vitals only once daily. -They were not waking up the clients to check their vitals. They physician did not feel that it was necessary to wake the clients up for vitals.	V 220		

CAIYALYNN BURRELL
CHILD CRISIS
CENTER

DHSR - Mental Health

FEB 18 2019

Lic. & Cert. Section

February 8, 2019

Susan McMickle
NC Department of Health and Human Services
2718 Mail Service Center
Raleigh, NC 27699-2718

Dear Ms. McMickle:

Attached please find the Plans of Correction for each of our deficiencies cited from the survey completed at our facility on January 16, 2019.

Please let me know if you have any questions.

Sincerely,

Pam Coppedge, RN

Pam Coppedge, RN
Director