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 _____	C 08/02/2019

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V 000	INITIAL COMMENTS A complaint survey was completed on 8/2/19. The complaint was unsubstantiated (Intake #NC00153767). A deficiency was cited. 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 270	27G .5002 Facility Based Crisis - Staff 10A NCAC 27G .5002 STAFF (a) Each facility shall maintain staff to client ratios that ensure the health and safety of clients served in the facility. (b) Staff with training and experience in the provision of care to the needs of clients shall be present at all times when clients are in the facility. (c) The facility shall have the capacity to bring additional staff on site to provide more intensive supervision, treatment, or management in response to the needs of individual clients. (d) The treatment of each client shall be under the supervision of a physician, and a physician shall be on call on a 24-hour per day basis. (e) Each direct care staff member shall have access at all times to qualified professionals who are qualified in the disability area(s) of the clients with whom the staff is working. (f) Each direct care staff member shall be trained and have basic knowledge about mental illnesses and psychotropic medications and their side effects; mental retardation and other developmental disabilities and accompanying	V 270		

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V 270	Continued From page 1 behaviors; the nature of addiction and recovery and the withdrawal syndrome; and treatment methodologies for adults and children in crisis. (g) Staff supervision shall be provided by a qualified professional as appropriate to the client's needs. This Rule is not met as evidenced by: Based on interview and record review the facility failed to maintain client to staff ratios that ensure the health and safety for 2 of 2 former clients audited (Former Client (FC) #3 and #4). The findings are: Review on 7/31/19 and 8/2/19 of the record for FC#3 revealed: -Admission date of 6/19/19 and discharge on 7/11/19. -Diagnoses of Schizoaffective Disorder-Bipolar Type, Intellectual Development Disability-Moderate, Borderline Personality Disorder and Post Traumatic Stress Disorder. Review on 7/31/19 and 8/2/19 of the record for FC#4 revealed: -Admission date of 7/9/19 and discharge on 7/10/19. -Diagnosis of Bipolar Disorder. -Physician note dated 7/10/19 to discharge "AMA" [against medical advice]. Review on 7/31/19 of the facility incident reports included: -Incident occurred on 7/10/19 which involved FC#4 - "Consumer allowed female (FC#3) consumer to enter his room for the purpose of having sex. Staff when doing rounds, interrupted prior to sexual intercourse. Bother consumers	V 270		

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denied anything happened. Consumer was discharged for violating policy."
- " ...how this type of incident may be prevented ..." - "All consumers are informed of rules upon admission. Male consumers are housed on Halls A & B. Female consumers housed on Halls C&D. Consumers are monitored every 15 minutes.
-Incident report was completed by the Facility Director on 7/15/19.

Review on 7/31/19 of the statement completed by the Clinical Director attached to the incident report revealed:
- "On July 11, 2015 ...[FC#3] was in my office talking wit me about personal concerns she was having.
I ask ...[FC#3] to set out of the office, explaining that I needed to obtain something from the nurses' station.
...[FC#3] walked with me toward the nurse's station, within no more that 3 min's I walked back to my office and was called up front by CSW stating they were doing around and found ... [FC#3] in a male consumer's room that the male consumer had his pants down.
Both consumers had left the room by the time I spoke to them, both the male consumer and ... [FC#3] denied anything happening. Male consumer continued to state "I would never do anything, she was looking at some information" consumer stated that he was having a hard time keeping his pants up due to them being too big and had to continue pulling them up.
Case was staffed with the ... [medical director]."

Interview on 8/1/19 with Crisis Support Worker #1 (CSW) revealed:
-He was assigned to the male hallways on 7/10/19.
-He was making rounds to check on the clients

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and housekeeping staff was also on the hallway.
-The door for FC#4 was closed and as he opened the door to check on the client, he observed FC#4 on his knees and FC#3 was on the bed with her pants down.
-FC#4 had his pants down "a little" and was performing oral sex on FC#3.
-CSW #1 separated the two client and went to the "head clinician" to report the incident.
-CSW #1 informed the Clinical Director of what he had observed.
-The Clinical Manager took FC#4 to the office and asked some questions, but he denied anything happened.

Interview on 7/31/19 with CSW #2 revealed:
-She was assigned to monitor the female hallways on 7/10/19
-She was not present in the facility when the incident occurred.
-She had left the facility to go pick up lunch for the clients.
-She left the facility around 12 or a few minutes after and returned around 12:30-12:45pm.
-FC#4 was present at the facility when she left, but not present when she returned.
-She was not aware of the incident until later in her shift.
-Two staff are always on shift and they rotate going to pick up meals.

Interview on 8/2/19 with the housekeeping staff working on 7/10/19.
-He was present on 7/10/19 when CSW#1 opened the door to the room of FC#4.
-When the door was opened FC#4 was performing oral sex on FC#4.
-FC#4 was on the floor and FC#3 was on the bed.

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V 270	Continued From page 4 Interview on 7/31/19 with the Clinical Director revealed: -On 7/10/19 FC#3 was in her office talking with FC#3 and she informed FC#3 she needed to walk up front to get a record. -CSW#1 came to her while she was walking in the hall within a 2-3 minutes after she had left FC#3. -CSW#1 reported FC#3 was in the room of FC#4. -CSW#1 reported the clients had their pants down but did not provide any further detail. -Both clients were also coming down the hallway when CSW#1 reported the incident. -She brought FC#4 into the observation room to discuss the incident and he strongly denied anything occurred. -There was not enough time for anything to occur between the two clients because FC#3 was just in her office. -She then staffed the incident with the physician and nurse due to the violation of policy. -Client was discharged due to violation of policy and he left the facility. Interview on 7/31/19 and 8/2/19 with the Nurse Manager revealed: -It was her responsibility to supervise the CSW. -She was meeting with the medical director on the day the incident occurred. -She was not aware CSW#2 had left the unit to pick up lunch. -When a CSW was off the unit the other CSW picks up the monitoring. -FC#3 had been meeting with the medical director approximately 6 minutes prior to the Clinical Director coming back to the office. -The Clinical Director stated she needed to staff something with the Nurse Manager and medical director. -The Clinical Director reported "oral sex" was	V 270		

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going on between FC#3 and FC#4.
-The medical director discharged FC#4.

Interview on 7/31/19 with the Clinician who worked with FC#3 revealed:
-Upon her return from lunch on 7/10/19 the Clinical Director and FC#3 were both coming down the hallway.
-The Clinical Director reported to her that FC#4 and FC#3 were found in the room together.
-She reported that FC#4 was having oral sex with FC#3.
-FC#3 was upset because she wanted to tell her what happened before the Clinical Director reported the incident.
-FC#3 reported to the Clinician that she did not have sex with him but did this instead.
-The Clinician discussed the dangers of unprotected sexual contact.

Interview on 7/31/19 and 8/2/19 with the Facility Director revealed:
-He was not present in the unit on 7/10/19.
-The Clinical Director reported that while the CSW#1 was doing rounds he found FC#3 in the room of FC#4.
-The Clinical Director reported to the Director that nothing occurred between the two clients.
-She further reported that FC#3 had only been out of her sight for about 3 minutes.
-The Director informed the Clinical Director if the CSW intervened before anything occurred between the clients an incident report was not necessary.
-The Director was not made aware any physical contact between the two clients.
-FC#4 was discharged on 7/10/19 due to having a female present in his room.
-He completed the incident report when he was asked by the care coordinator why an incident

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V 270	Continued From page 6 report was not submitted. -He requested a statement from the Clinical Director and completed the incident report based on the information she provided. -An incident report should have been completed based on what the CSW reported to the Clinical Director.	V 270		