STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-214	A. BUILDING: _____ B. WING _____	05/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chyl H. Briings PHOENIX COUNSELING CENTER-RESIDENTIAL WING	2505 COURT DRIVE, RESIDENTIAL WING GASTONIA, NC 28054

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V 000	INITIAL COMMENTS A complaint survey was completed on May 26, 2020. The complaint was substantiated (Intake #NC165150). A deficiency was cited. The facility is licensed for the following service categories: 10A NCAC 27G .3100 Non-hospital Medical Detoxification for Individuals who are Substance Abusers; 10A NCAC 27G .3300 Outpatient Detoxification for Substance Abuse; 10A NCAC 27G .3400 Residential Treatment/Rehabilitation for Individuals with Substance Abuse Disorders, and 10A NCAC 27G .5000 Facility Based Crisis Service for Individuals of all Disability Groups.	V 000	10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS is not met as evidenced by: Based on interview and record review, one of one nurses (Licensed Practical Nurse #1) failed to demonstrate the knowledge, skills, and abilities of the population served. Review on 5/18/2020 and 5/19/2020 of the facility's Incident Reports revealed: -No incident report completed on Discharged Client #1 becoming ill in the early morning hours on 5/11/2020 requiring emergency medical services transport to the local hospital. -Lack of contact to Discharged Client #1 emergency contact during the illness. PLAN OF CORRECTION: 1. Review of Phoenix Counseling Center incident report (IRIS) training and update as appropriate by the Quality Assurance Administrator, Charge Nurse and Crisis Services Directors. 2. Review of Phoenix Counseling Center Consumer Transfer for Medical Services protocol for appropriate requirements, update as necessary by the Quality Assurance Administrator, Charge Nurse and Crisis Services Directors. 3. Training to all crisis unit staff on incident reporting procedure by the Charge Nurse and Quality Assurance Administrator. 4. Documentation of training competency demonstrated by pre and post testing. 5. Training to all crisis unit staff on updated Consumer Transfer for Medical Services protocol by Charge Nurse. 6. Training on consumer consent to contact emergency contact by Charge Nurse. 7. Rounding sheets evaluated by Medical Records daily to ensure all incident	6/15/20 6/15/20 7/1/20 7/1/20 7/1/20 7/1/20

			reporting has been sent to the Quality Assurance Administrator.	6/5/20
			8. During nurse's shift reporting, both nurses will evaluate that the emergency contact has been contacted when a consumer is transferred to the hospital and/or during illness, if consent has been signed.	6/5/20
			9. Nurse on duty at the time of the hospital transfer and/or significant illness will document on the rounding sheet and in the medical record that the emergency contact was contacted if consent has been signed by consumer.	6/5/20
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A	V 109		

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V 109	Continued From page 1 NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (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. (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. This Rule is not met as evidenced by: Based on interview and record review, one of one nurses (Licensed Practical Nurse #1) failed to demonstrate the knowledge, skills, and abilities of the population served. The findings are: Review on 5/18/2020 of Licensed Practical Nurse #1's record revealed: -Hired 4/6/2020; -Incident Reporting completed 4/6/2020. Review on 5/18/2020 and 5/19/2020 of the facility's Incident Reports revealed: -No incident report completed on Discharged Client #1 becoming ill in the early morning hours on 5/11/2020 requiring emergency medical services transport to the local hospital. Review on 5/19/2020 - 5/22/2020 of Discharged Client #1's record revealed: -Progress notes dated 5/10/2020 7pm - 7am shift	V 109		

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V 109	Continued From page 2 revealed Discharged Client #1 was sick and sent to the local hospital; -Consent for Treatment and Emergency Information form dated 5/7/2020 revealed "we request your consent to contact individuals of your choosing should an emergency occur" listing Discharged Client #1's mother and phone number. Review on 5/26/2020 of the facility's Protocol dated 12/27/2012 updated 5/2015 and 7/2018 titled Consumer Transfer for Medical Services revealed: -Responsible department was nursing; - ..."the consumers emergency contact will be notified ..." Interview on 5/18/2020 with Discharged Client #1 revealed: -Got sick at the facility and did not receive the proper medical care; -Had wanted to leave the facility for days to go to the hospital but was told she was detoxing and did not need hospital care; -Fell twice at the facility on 5/11/2020 and hit her head; -Was told to go to her room on 5/11/2020 when she fell and hit her head; -Emergency contact was not notified when she went to the hospital; -Will send documentation from the hospital to Division of Health Service Regulation surveyor (no documentation was ever sent). Interview on 5/22/2020 with Licensed Practical Nurse #1 revealed: -Worked at the facility on an as needed basis; -During shift report on 5/10/2020 at approximately 7pm, the Registered Nurse leaving shift reported that Discharged Client #1 had been sick	V 109		

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V 109	Continued From page 3 throughout the day with vomiting and diarrhea. Around 11pm, vitals were assessed and were stable. Discharged Client #1 was given Gatorade and anti-nausea medication and returned to bed. In the early morning hours of 5/11/2020, Discharged Client #1 presented to the staff window reporting feeling ill. Discharged Client #1 sat on the floor. Licensed Practical Nurse #1 and Staff #1 assisted Discharged Client #1 and assessed vitals. After vitals were taken, Licensed Practical Nurse #1 had received medical orders to send Discharged Client #1 to the hospital. Meanwhile, Discharged Client #1 requested to use the restroom and was being accompanied by Staff #1. Discharged Client #1 had a loose bowel movement in her pants prior to making it to the restroom. Staff #1 assisted Discharged Client #1 in the restroom and assisted with getting clean scrubs. Staff #1 remained with Discharged Client #1 until emergency medical services arrived. Discharged Client #1 never lost consciousness; - Did not notify Discharged Client #1's emergency contact regarding the incident; -Did not complete an incident report regarding the incident. Interview on 5/22/2020 with Staff #1 revealed: - Worked as a Crisis Support Worker on third shift; -Discharged Client #1 came to the staff area in the early morning hours of 5/11/2020 complaining of not feeling well and was redirected to the Licensed Practical Nurse #1. Staff #1 worked with Licensed Practical Nurse #1 to care for Discharged Client #1 and took her vitals. Discharged Client #1 sat on the floor but did not lose consciousness. After vitals were taken, Licensed Practical Nurse #1 had received medical orders to send Discharged Client #1 to the hospital. Meanwhile, Discharged Client #1	V 109		

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V 109	Continued From page 4 requested to use the restroom and was being accompanied by Staff #1. Discharged Client #1 had a loose bowel movement in her pants prior to making it to the restroom. Staff #1 assisted Discharged Client #1 in the restroom and assisted with getting clean scrubs. Staff #1 remained with Discharged Client #1 until emergency medical services arrived. Discharged Client #1 never lost consciousness. Interview on 5/26/2020 with the Quality Assurance Administrator revealed: -Understood the citation surrounding the lack of incident reporting when Discharged Client #1 became ill requiring transport to the local hospital. Also understood the concern with the lack of contact to Discharged Client #1's emergency contact during the illness.	V 109		