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V 000	INITIAL COMMENTS An annual survey was completed on August 5, 2021. Deficiencies were cited. This facility is licensed for the following service categories: 10 NCAC 27G .3100 Non-hospital Medical Detoxification-Individuals who are Substance Abusers and 10 NCAC 27G 5000 Facility Based Crisis Service for Individuals of all Disability Groups.	V 000		
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. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire and disaster drills were held quarterly and repeated on each shift. The findings are: Interview on 8/2/21 the Clinician/Program Supervisor stated there were 2 shifts, 7 am - 7	V 114		

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V 114	Continued From page 1 pm, and 7 pm - 7 am. Review of fire and disaster drills from 7/1/20 - 6/30/21 revealed: -No disaster drills were documented from 7/1/20 - 6/30/21 -Quarter 7/1/20 - 9/30/20: No fire drills documented. -Quarter 1/1/21 - 3/31/21: No fire drills documented on the 7 pm - 7 am shift. -Quarter 4/1/21 - 6/30/21: No fire drills documented on the 7 am - 7 pm shift. Interview on 8/2/21 the Clinician/Program Supervisor stated: -They were not able to practice fire or disaster drills since March of 2020 due to the pandemic. -The fire and disaster drill procedures were to evacuate clients to the intake hallway. -The intake hallway was not large enough to maintain 6 feet social distance between clients and staff. -The door between the intake hall and the adjacent clinical area was a fire door. -They did not practice evacuation outdoors for safety reasons, even though the facility had a secured fence around the perimeter of the building.	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	V 220		

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V 220	Continued From page 2 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 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 reviews and interviews, the facility failed develop and implement a written policy that ensured vital signs during the detoxification process were monitored and recorded at least every four hours for the first 24 hours and at least 3 times daily thereafter for 3 of 3 clients audited (#1, #2, #3). The finding are: Finding #1: Review on 8/2/21 and 8/4/21 of client #1's record revealed: -52 year old male admitted 7/30/21 at 12:29 pm. -Diagnoses included methamphetamine induced psychotic disorder; other stimulant dependence, uncomplicated. -7/30/21 "Measurable Objective....The overall goal is a safe detox ..." -Crisis Treatment Plan dated 7/30/21 documented vital signs would be obtained twice daily. Review on 8/2/21 and 8/4/21 of client #1's Vital Signs Report revealed:	V 220		

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V 220	Continued From page 3 -Vital Signs Report was printed 8/2/21 at 2:43 pm. -Admission vital signs documented 7/30/21 at 11:45 am (Admission) : Pulse (P) = 87; Respirations (R) = 20; Temperature (T) = 97.8 Degrees Fahrenheit (°F); Blood Pressure (BP) = 126/90 -1st 24 hours: -pulse rate, blood pressure and temperature not documented between admission and 7/31/21 at 8 am (P = 84; R = 17; T = 98.2 °F; BP = 129/81) -7/30/21 at 4 pm: "Comments: client sleeping;" R = 16. -2nd 24 hours: pulse rate, blood pressure and temperature were documented twice: -7/31/21 at 8 pm: "Comments: guest is sleeping; respirations unlabored;" R = 15. -8/1/21 at 8 am: P = 73; R = 14; T = 97.4 °F; BP = 148/81 -3rd 24 hours: pulse rate, blood pressure and temperature were documented twice: -8/1/21 at 8 pm: P = 75; R = 18, T = 98.1 °F; BP = 121/87 -8/2/21 at 8 am: P = 77; R = 16, T = 98 °F; BP = 124/90 Finding #2: Review on 8/2/21 and 8/4/21 of client #2's record revealed: -48 year old female admitted 8/1/21 at 9:50 am. -Diagnoses included alcohol use with alcohol-induced disorder. -Medications ordered for withdrawal included: Ativan and Neurontin. -Crisis Treatment Plan dated 8/1/21 documented vital signs would be obtained twice daily. Review on 8/2/21 and 8/4/21 of client #2's Vital Signs Report revealed: -Vital Signs Report was printed 8/2/21 at 2:41 pm.	V 220		

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-1st 24 hours: pulse rate, blood pressure and temperature were not documented every 4 hours between 8/1/21 at 8 pm and 8/2/21 at 8 am:
-8/2/21 at 12 am: "Comments: no acute distress; asleep at this time" R = 18
-8/2/21 at 4 am: "Comments: asleep at this time" R = 18

Finding #3:
Review on 8/2/21 and 8/4/21 of client #3's record revealed:
-33 year old female admitted 7/30/21 at 7:05 pm.
-Diagnoses included unspecified psychosis; stimulant use.
-Medications ordered for withdrawal included: Neurontin, Clonidine, Bentyl, Cyclobenzaprine
-Crisis Treatment Plan dated 7/30/21 documented vital signs would be obtained twice daily.

Review on 8/2/21 and 8/4/21 of client #3's Vital Signs Report revealed:
-Vital Signs Report was printed 8/2/21 at 2:40 pm.
-1st 24 hours: pulse rate, blood pressure and temperature were not documented or attempted every 4 hours
-No pulse rate, blood pressure and temperature recorded from admission until 7/31/21 at 8 am (P = 108; R = 17; T = 98.1 °F; BP = 119/86)
-7/31/21 at 12 pm: "Refused"
-7/31/21 at 6:33 pm: "Comments: Triage Vitals" P = 114; R = 18; T = 97.8 °F; BP = 135/90
-7/31/21 at 8 pm "Comments: guest is sleeping; respirations unlabored;" R = 14.

Review on 8/4/21 of the policy, "Assessment & Treatment Planning" dated 1/30/17 revealed:
-"Vitals will be taken at triage and documented on the Nursing Assessment vitals screen in the

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V 220	Continued From page 5 electronic health record." -"Once a participant is admitted, vitals shall be taken every 6 hours or as ordered by a Provider." Interview on 8/4/21 the Nurse Manager stated: -Vital signs were done according to standard protocol. -If on COWS (Clinical Opiate Withdrawal Scale) vital signs are ordered every 4 hours. If they score 3 or less this will decrease to having vital signs daily or as needed. -If a client is not on COWS, the facility policy is daily vitals.	V 220		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and	V 366		

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V 366	Continued From page 6 (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the	V 366		

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LME in whose catchment area the provider is located and to the LME where the client resides, if different; and
(D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and
(3) immediately notifying the following:
(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;
(B) the LME where the client resides, if different;
(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;
(D) the Department;
(E) the client's legal guardian, as applicable; and
(F) any other authorities required by law.

This Rule is not met as evidenced by:
Based on record reviews and interviews the

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V 366	Continued From page 8 facility failed to develop and implement written policies governing their response to incidents as required. The findings are: Finding #1: Review on 8/2/21 and 8/4/21 of client #1s record revealed: -52 year old male admitted 7/30/21. -Diagnoses included methamphetamine induced psychotic disorder; other simulant dependence, uncomplicated. -The 9 pm scheduled doses of the following medications (ordered 7/30/21) were documented as refused/missed: -Ambien 10 mg (sleep) refused on 7/31/21 and dose was documented as "missed" on 8/1/21. -Zyprexa 10 mg (depression) refused on 7/31/21. -Clonazepam 1 mg (mood disorder) refused on 7/31/21. Finding #2: Review on 8/2/21 and 8/4/21 of client #3s record revealed: -33 year old female admitted 7/30/21. -Diagnoses included unspecified psychosis; stimulant use. -The scheduled doses of the following medications (ordered 7/30/21) were documented as refused: -Haloperidol 5mg (psychosis/agitation) "one time STAT" dose on 7/30/21 at 6:45pm refused; twice daily order, refused all doses (6) between 7/30/21 (9am) - 8/2/21 (9am). -Multivitamin daily refused 8/2/21 at 9am. -Thiamine 100 mg (supplement) ordered twice daily, refused at 8 pm on 8/1/21, and 10:52 am on 8/2/21. -Neurontin 300 mg (withdrawal) ordered 3	V 366		

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V 366	Continued From page 9 times daily, client #3 refused the following doses: 7/31/21 at 3:03 pm and 10 pm; 8/1/21 at 9:13 am, 3:22 pm, and 8 pm; and 8/2/21 at 10:52 am. Review on 8/2/21 of the facility incident reporting log revealed no level 1 incident response reports documented for medication refusals or missed doses between 2/5/21 and 8/2/21. Interview on 8/4/21 the Nurse Manager stated: -Nurses documented refusals in the electronic medication administration record (MAR). -The providers had access to the MARs and reviewed daily. -Incident reports were not completed for medication refusals.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information;	V 367		

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V 367	Continued From page 10 (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a	V 367		

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report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:
(1) medication errors that do not meet the definition of a level II or level III incident;
(2) restrictive interventions that do not meet the definition of a level II or level III incident;
(3) searches of a client or his living area;
(4) seizures of client property or property in the possession of a client;
(5) the total number of level II and level III incidents that occurred; and
(6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to report all level II incidents within 72 hours of becoming aware of the incident. The findings are:

Review on 8/2/21 of the North Carolina Incident Response Improvement System (IRIS) revealed no level II incident reports had been submitted by the facility.

Review on 8/3/21 of the IRIS revealed the

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V 367	Continued From page 12 following level II incident reports had been submitted on 8/3/21. 1. Former client (FC) #4 was placed in a sitting restrictive intervention on 6/24/21 at 8:52 am. 2. FC#5 was placed in a standing restrictive intervention on 5/28/21 at 7:15 pm. 3. FC#6 was placed in a standing restrictive intervention on 5/28/21 at 7:15 pm. 4. FC#7 attempted suicide on 3/24/21 at 4:30 pm. Interview on 8/3/21 the Risk Manager stated: -The Program Supervisor had submitted internal incident reports for the level II incidents. -It was the responsibility of Risk Management to submit level II incident reports in the IRIS. -She was aware of the requirement for level II incident reporting, but for internal reasons, the reports had not been submitted as required. -Once she had been made aware the level II incident reports had not been reported as required, she made sure IRIS reports had been submitted on 8/3/21 for the level II incidents.	V 367		
V 539	27F .0102 Client Rights - Living Environment 10A NCAC 27F .0102 LIVING ENVIRONMENT (a) Each client shall be provided: (1) an atmosphere conducive to uninterrupted sleep during scheduled sleeping hours, consistent with the types of services being provided and the type of clients being served; and (2) accessible areas for personal privacy, for at least limited periods of time, unless determined inappropriate by the treatment or habilitation team. (b) Each client shall be free to suitably decorate his room, or his portion of a multi-resident room,	V 539		

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DIX CRISIS CENTER	**215-B MEMORIAL DRIVE JACKSONVILLE, NC 28546**

(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 539	Continued From page 13	V 539		

with respect to choice, normalization principles, and with respect for the physical structure. Any restrictions on this freedom shall be carried out in accordance with governing body policy.

This Rule is not met as evidenced by:
Based on record reviews, observations and interviews, the facility failed to provide for personal privacy by having cameras installed in client bedrooms for continuous video surveillance, affecting 3 of 3 clients audited (#1, #2, #3). The findings are:

Finding #1:
Review on 8/2/21 and 8/4/21 of client #1's record revealed:
-52 year old male admitted 7/30/21 at 12:29 pm.
-Diagnoses included methamphetamine induced psychotic disorder; other stimulant dependence, uncomplicated.
-Crisis Treatment Plan dated 7/30/21 did not document the need to restrict personal privacy.
-Client #1 signed the "RI International Consent for Treatment & Acknowledgement Form" that included "I agree to participate with the understanding there are video cameras in the community areas and participant rooms."

Interview on 8/2/21 client #1 stated he was "ok" with the camera in his room; nothing made him feel uncomfortable.

Finding #2:
Review on 8/2/21 and 8/4/21 of client #2's record revealed:
-48 year old female admitted 8/1/21 at 9:50 am.
-Diagnoses included alcohol use with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL067-203	A. BUILDING: ______ B. WING ______	08/05/2021

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V 539	Continued From page 14 alcohol-induced disorder. -Crisis Treatment Plan dated 8/1/21 did not document the need to restrict personal privacy. -Client #1 signed the "RI International Consent for Treatment & Acknowledgement Form" that included "I agree to participate with the understanding there are video cameras in the community areas and participant rooms." Interview on 8/2/21 client #2 stated: -The cameras made her uncomfortable; it "invades my civil rights." -The staff told them to change clothes in the bathroom because of the camera in their bedroom. -When she was first admitted she forgot and changed in her room on one occasion. Finding #3: Review on 8/2/21 and 8/4/21 of client #3's record revealed: -33 year old female admitted 7/30/21 at 7:05 pm. -Diagnoses included unspecified psychosis; stimulant use. -Crisis Treatment Plan dated 7/30/21 did not document the need to restrict personal privacy. -Client #1 signed the "RI International Consent for Treatment & Acknowledgement Form" that included "I agree to participate with the understanding there are video cameras in the community areas and participant rooms." Interview on 8/2/21 client #3 stated: -Staff had not explained a camera was in her bedroom; she did not know one was in her room. -Staff told her to change clothes in the bathroom. Observations during a tour of the facility on 8/2/21 between 11 am and 12 pm revealed a surveillance camera was mounted in the corner	V 539		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 539	Continued From page 15 at the ceiling in every client bedroom. Interview on 8/4/21 the Clinician/Program Supervisor stated: -On admission clients signed a consent for camera surveillance in the bedrooms. -Cameras in client bedrooms had been in place from the beginning of the program. -Staff monitored the cameras from a work station with privacy screens over the monitors to protect client privacy. -The cameras had been beneficial for client safety. -There had been no successful suicide attempts since the program opened. -The camera surveillance had helped save lives.	V 539		