Division of Health Service Regulation (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL029-134 08/31/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1104 R S MAIN STREET **DAVIDSON CRISIS CENTER** LEXINGTON, NC 27292 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRFFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 000 INITIAL COMMENTS V 000 An annual survey was completed on 8/31/21. Deficiencies were cited. This facility is licensed for the following service category: 10A NACA 27G .5000 Facility Based Crisis Service for Individuals of all Disability Groups V 536 V 536 27E .0107 Client Rights - Training on Alt to Rest. - All Staff must attend 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE atternatives to restrictive **INTERVENTIONS** (a) Facilities shall implement policies and interventions training practices that emphasize the use of alternatives on Day 2 of orientation prior to delivery of to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall Services demonstrate competence by successfully + Staff will not be placed completing training in communication skills and other strategies for creating an environment in on schedule antil which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or training is complete property damage is prevented. This will be responsibility of center directors (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. monitoring will occur (d) The training shall be competency-based, include measurable learning objectives, during each orientation measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the Refresher courses will course (e) Formal refresher training must be completed be held annually by each service provider periodically (minimum annually) Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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PRINTED: 09/09/2021 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING: B. WING MHL029-134 08/31/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1104 B S MAIN STREET **DAVIDSON CRISIS CENTER** LEXINGTON, NC 27292 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) with all staff required V 536 | Continued From page 1 V 536 to attend.
- Center director will devise check list to ensure all (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the Staff attend required training a maniored @ annual training period following core areas: knowledge and understanding of the (1) people being served; recognizing and interpreting human (2)behavior: (3)recognizing the effect of internal and external stressors that may affect people with disabilities: strategies for building positive (4)relationships with persons with disabilities; recognizing cultural, environmental and organizational factors that may affect people with disabilities; recognizing the importance of and assisting in the person's involvement in making decisions about their life; skills in assessing individual risk for escalating behavior; communication strategies for defusing and de-escalating potentially dangerous behavior; positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years.

(1)

(A)

(B) (C)

(2)

outcomes (pass/fail);

Documentation shall include:

instructor's name;

who participated in the training and the

when and where they attended; and

The Division of MH/DD/SAS may

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL029-134	B. WING		30	3/31/2021	
	NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1104 B S MAIN STREET						
DAVIDSO	N CRISIS CENTER		ON, NC 27292				
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	(X5) COMPLETE DATE		
	review/request this do (i) Instructor Qualifical Requirements: (1) Trainers sha by scoring 100% on te aimed at preventing, reducing a passing of instructor training proof (3) The training competency-based, in objectives, measurable observation of behavior measurable methods to failing the course. (4) The content service provider plans approved by the Divisite to Subparagraph (i)(5) (5) Acceptable in shall include but are no (A) understanding (B) methods for course; (C) methods for course; (C) methods for performance; and (D) documentation (B) Trainers shall teaching a training proof reducing and eliminatir interventions at least o review by the coach. (7) Trainers shall aimed at preventing, re need for restrictive inter annually.	cumentation at any time. tions and Training  Il demonstrate competence esting in a training program educing and eliminating the erventions. Il demonstrate competence grade on testing in an irram. shall be clude measurable learning e testing (written and by or) on those objectives and or determine passing or  of the instructor training the to employ shall be on of MH/DD/SAS pursuant of this Rule. Instructor training programs of limited to presentation of: grade adult learner; teaching content of the evaluating trainee  on procedures. I have coached experience gram aimed at preventing, graph the need for restrictive ne time, with positive  I teach a training program ducing and eliminating the rventions at least once	V 536				

		TATEMENT OF DEFICIENCIES  ND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			COMPLETED	
			MHL029-134	B. WING		08.	/31/2021	
NAME OF PROVIDER OR SUPPLIER  DAVIDSON CRISIS CENTER  STREET ADDRESS, CITY, STATE, 1104 B S MAIN STREET LEXINGTON, NC 27292								
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	V 536	training for at least thr  (1) Docume  (A) who participa outcomes (pass/fail);  (B) when and w  (C) instructor's r  (2) The Division request and review thi  (k) Qualifications of C  (1) Coaches sha requirements as a trai  (2) Coaches sha the course which is be  (3) Coaches sha competence by compl train-the-trainer instruct	shall maintain al and refresher instructor ree years. Intation shall include: ated in the training and the where attended; and name. In of MH/DD/SAS may its documentation any time. Coaches: all meet all preparation ner. all teach at least three times sing coached. all demonstrate etion of coaching or	V 536				
			ws and interviews the staff completed annual ternatives for restrictive					
	Review on 8/31/21 of Licensed Practical Nurse's (LPN) record revealed: - Hired on 8/26/19 - Job Title: Psychiatric Nurse - Documentation of completion of training in alternatives to restrictive interventions expired on							

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL029-134	B. WING		08/31/2021	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, ST	ATE, ZIP CODE		
DAVIDSO	N CRISIS CENTER		IAIN STREET N, NC 27292			
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V 536	8/27/19 - Documentation of re alternatives to restrict completed on 10/25/2 Interview on 8/31/21 v -She had missed one pandemic, but could r she missed.  Interview on 8/31/21 v - Aware LPN missed s - LPN signed up for w - "Due to COVID we h	fresher training in the interventions was 0 vith LPN revealed: training due to the Covid-19 tot specify which training vith Director revealed: some trainings that she is lacking right now	V 536			
V 537	10A NCAC 27E .0108 SECLUSION, PHYSIC ISOLATION TIME-OU (a) Seclusion, physica time-out may be employed been trained and have competence in the proto these procedures. staff authorized to employed procedures are retrain competence at least a (b) Prior to providing of disabilities whose trea includes restrictive inteservice providers, employed in the procedures and the procedures are retrain competence at least a (b) Prior to providing of disabilities whose trea includes restrictive inteservice providers, employed in the procedures and the procedures are retrained in the procedure and the procedure are retrained in the procedure and the procedure are retrained in the procedure and the procedure are retrained in the procedure are retrain	CAL RESTRAINT AND T all restraint and isolation byed only by staff who have demonstrated uper use of and alternatives Facilities shall ensure that bloy and terminate these ed and have demonstrated unually. iriect care to people with trent/habilitation plan erventions, staff including bloyees, students or ete training in the use of straint and isolation time-out e interventions until the	V 537	-Center director wi ensure at least 1 staff person is an is an is an in convert RI train - Daymark will re- face to face RI train face to face RI train effective immedia to will be updays annually -Center director is devise check list ensure all staff	ainings attly al	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Value A Martin Control Control	E CONSTRUCTION	(X3) DATE S	
			A. BUILDING:			
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NAME OF F	PROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STA	ATE, ZIP CODE		
DAVIDSO	N CRISIS CENTER		AIN STREET N, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 537	(c) A pre-requisite for demonstrating competraining in preventing, the need for restrictive (d) The training shall kinclude measurable lemeasurable testing (with behavior) on those object of the training shall kinclude measurable testing (with behavior) on those object of the training shall kinclude measurable testing (with behavior) on those object of the testing (e) Formal refresher to the service provides annually).  (f) Content of the training provider plans to employ the Division of MH/DD Paragraph (g) of this Fing) Acceptable training but are not limited to, provide annually (f) refresher information of the use of restrictive in (f) guidelines on (understanding immineration) of least restrictive intervention (f) the use of entitle interventions which incompasses ment and monitipsychological well-being use of restrictive interventions (f) prohibited provided for the service for	taking this training is tence by completion of reducing and eliminating in interventions. The competency-based, sarning objectives, written and by observation of expectives and measurable in passing or failing the straining must be completed der periodically (minimum). The completed der periodically (minimum) and the service lower than the se	V 537	attend required to provide orient to during annual	ainin tavi, recev	rgt crs.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY
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	ROVIDER OR SUPPLIER	1104 B S M	DRESS, CITY, ST MAIN STREET DN, 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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
V 537	(8) documentation (h) Service providers a documentation of initia at least three years. (1) Documentation (A) who participa outcomes (pass/fail); (B) when and with (C) instructor's in (C) The Division review/request this doto (i) Instructor Qualificate Requirements: (1) Trainers shate by scoring 100% on the aimed at preventing, reneed for restrictive interesting the use of seand isolation time-out. (3) Trainers shate by scoring a passing goinstructor training proguing tructor training proguing competency-based, in objectives, measurable observation of behavior measurable methods to failing the course. (5) The content service provider plans approved by the Divisito Subparagraph (j)(6) (6) Acceptable in shall include, but not boto: (A) understanding	on methods/procedures. shall maintain al and refresher training for ion shall include: ated in the training and the here they attended; and name. of MH/DD/SAS may cumentation at any time. tion and Training  Il demonstrate competence esting in a training program educing and eliminating the erventions. Il demonstrate competence sting in a training program clusion, physical restraint  Il demonstrate competence rade on testing in an ram. shall be clude measurable learning e testing (written and by or) on those objectives and o determine passing or  of the instructor training the to employ shall be on of MH/DD/SAS pursuant	V 537			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
MHL029-134		B. WING		08/31/2021		
NAME OF PROVIDER OR SUPPLIER  DAVIDSON CRISIS CENTER  STREET ADDR  1104 B S MA  LEXINGTON				TE, ZIP CODE		
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V 537	(D) documentati (7) Trainers sha annually and demons of seclusion, physical time-out, as specified Rule. (8) Trainers sha CPR. (9) Trainers sha in teaching the use of least two times with a coach. (10) Trainers sha use of restrictive inter annually. (11) Trainers sha instructor training at le (k) Service providers documentation of initi training for at least the (1) Documental (A) who particip outcome (pass/fail); (B) when and w (C) instructor's (2) The Divisior review/request this do (1) Qualifications of C (1) Coaches sh requirements as a tra (2) Coaches sh times, the course while	of trainee performance; and on procedures. all be retrained at least trate competence in the use restraint and isolation in Paragraph (a) of this all be currently trained in all have coached experience restrictive interventions at positive review by the all teach a program on the ventions at least once all complete a refresher east every two years. shall maintain all and refresher instructor ree years. Ition shall include: atted in the training and the ventions at least once attended; and name. In of MH/DD/SAS may be commentation at any time. The oaches: all meet all preparation iner. all teach at least three ch is being coached. all demonstrate letion of coaching or ction. The process is the same in the same.	V 537			

Division of Health Service Regulation

FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: B. WNG 08/31/2021 MHL029-134 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1104 B S MAIN STREET **DAVIDSON CRISIS CENTER** LEXINGTON, NC 27292 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 537 V 537 Continued From page 8 This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure staff completed training seclusion, physical restraint and isolation prior to providing services affecting 2 of 3 audited staff (#1 & the Human Service Clinician (HSC); and failed to ensure formal refresher training was completed at least annually affecting 1 of 3 audited staff (The Licensed Practical Nurse (LPN's). The findings are: Review on 8/31/21 of Licensed Practical Nurse's (LPN) record revealed: - Staff was hired on 8/26/19 - Job Title: Psychiatric Nurse - No training in seclusion, physical restraint and isolation time-out Review on 8/31/21 of Staff #1's record revealed: - Staff was hired on 5/24/21 - Job Title: Crisis Worker - No training in seclusion, physical restraint and isolation time-out Review on 8/31/21 of Human Service Clinician's (HSC) record revealed: - Staff was hired on 7/26/21 - Job Title: Human Service Clinician - She started working with clients before she received her training in seclusion, physical restraint and isolation time-out.

Division of Health Service Regulation

Interview with the LPN on 8/31/21 revealed:
- She had missed one training due to the
Covid-19 pandemic, but could not specify which

Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: \_\_\_ B. WING 08/31/2021 MHL029-134 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1104 B S MAIN STREET **DAVIDSON CRISIS CENTER** LEXINGTON, NC 27292 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 537 V 537 Continued From page 9 training she missed Interview with the HSC on 8/31/21 revealed: - She had been scheduled to receive training in seclusion, physical restraint and isolation time out on the Wednesday following her start date, but the training had been rescheduled. - She provided services to clients before having training in seclusion, physical restraint and isolation time-out on the Thursday after her start date - Completed the training in seclusion, physical restraint and isolation time-out on 8/4/21 Interview on 8/31/21 with the Director revealed: - training in seclusion, physical restraint and isolation time out is held the first week of employment - Aware LPN missed some trainings - LPN signed up for what she is lacking right now. - Something happened when Human Service Clinician began training, it had to be rescheduled - Not aware Staff #1 was missing training - "Due to COVID we had went virtual" - "We had to restart how we were doing things"

Division of Health Service Regulation

6899



Daymark Crisis Center 1104B S Main Street Lexington, NC 27292 336-300-8826

www.daymarkrecovery.org

September 15, 2021

Mental Health Licensure and Certification NC Division of Health Service Regulation 2718 Mail Service Center Raleigh, NC 27699-2718

Dear Ms. Rising:

Enclosed please find the plan of correction related to your findings of an audit performed 8-31-21 at Daymark Crisis Center, Lexington, NC.

Please let me know if you have further questions.

Thank you

Sincerely, Wharm Wilcox RN, BS, BSN

Sharon Wilcox, RN, BS, BSN FBC Operations Director Daymark Recovery Services

336-466-5404

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**DHSR-MH Licensure Sect**