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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on 11/3/21. The complaint was substantiated (Intake #NC181627). 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, 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 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	V 112		

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V 112	Continued From page 1 (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. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement a Person Centered Plan with 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 affecting 1 of 6 audited current clients (Client #5) and 1 of 1 audited former clients (FC #7). The findings are: Record review on 10/13/21 for Client #5 revealed: -Date of admission-10/6/21 -Diagnoses- Moderate Intellectual and Developmental Disability, bipolar, attention deficit hyperactivity disorder, depression, cannabis dependence, alcohol dependence, other stimulant dependence. -Treatment plan dated 10/7/21 goals included: -to abstain from using any substances -to report any change in psychiatric symptoms and to take all medications -will participate in psychiatric eval and take all medications as prescribed -wants to be linked to aftercare services, develop life-enriching skills, learn ways to actively participate in recovery and maintain mental health stability.	V 112		

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V 112	Continued From page 2 -There was no signature of the client or her guardian nor their participation in the development of her treatment plan. Record review on 10/13/21 for FC #7 revealed: -Date of admission-9/20/21- voluntary for alcohol detox. -Diagnoses- panic disorder and alcohol use disorder. -Treatment plan dated 9/21/21 goals included: -to abstain from drinking alcohol or using substances -to report any change in psychiatric symptoms and to take all medications as prescribed -will participate in psychiatric evaluation -will access unit aftercare staff as needed in order to learn about available resources within the community. -There was no signature or evidence FC #7 had participated in the development of his treatment plan. Interview on 10/13/21 with Client #5 revealed: -She didn't know her goals just needed a place to live. Interview with FC #7 on 10/20/21 revealed: -He had been treated unfairly at the facility by being locked in seclusion for 5 hours without staff monitoring. He was concerned for others who might not have a voice. Interview on 10/13/21 with Clinician #3 revealed: -Had been at facility 1 year and 2 months. -Was currently the only daytime clinician and was responsible for completing case management (including treatment planning), assessments, discharge planning, individual, family and group therapy for all residents. She also backed up intake when they needed help.	V 112		

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V 112	Continued From page 3 -She would pull clients after lunch for case management to determine what services were needed after discharge such as connecting to outpatient care or if homeless connect to housing such as shelter or longer term group home. -Other clinicians had left. She was the only one doing case management and discharge planning for all clients. -She had her own personal electronic signature pad for clients to sign but was not sure if previous clinicians had an electronic pad that worked.	V 112		
V 269	27G .5001 Facility Based Crisis - Scope 10A NCAC 27G .5001 SCOPE (a) A facility-based crisis service for individuals who have a mental illness, developmental disability or substance abuse disorder is a 24-hour residential facility which provides disability-specific care and treatment in a non-hospital setting for individuals in crisis who need short-term intensive evaluation, or treatment intervention or behavioral management to stabilize acute or crisis situations. (b) This facility is designed as a time-limited alternative to hospitalization for an individual in crisis. This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to provide individuals in crisis with treatment interventions or behavioral management to stabilize acute or crisis situations. The facility also operated outside of the scope of their license. The findings are: Finding A:	V 269		

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V 269	Continued From page 4 CROSS REFERENCE: 10A NCAC 27G.5002 Facility Based Crisis-Staff (V270). Based on record reviews and interviews the facility failed to provide additional staff to provide more intensive supervision, treatment or management in response to the needs of individual clients. CROSS REFERENCE: 10A NCAC 27E.0104(e1-2) Seclusion, Physical Restraint and Isolation Time-out and Protective Devices used for Behavioral Control (V518). Based on observation, record reviews and interviews, the facility failed to ensure staff were physically present to assess and monitor the physical and psychological well-being of the client throughout the duration of a restrictive intervention affecting 1 of 1 audited Former Client (FC #7). CROSS REFERENCE: 10A NCAC 27E.0104(e9) Seclusion, Physical Restraint and Isolation Time-out and Protective Devices used for Behavioral Control (V521). Based on record reviews and interview, the facility failed to ensure the required documentation was in the client record when a restrictive intervention was utilized affecting 1 of 1 audited former client (FC #7). CROSS REFERENCE: 10A NCAC 27E.0108 Training in Seclusion, Physical Restraint and Isolation Time-out (V537). Based on record reviews and interview, the facility failed to ensure 7 of 7 audited staff (Nurse #2, Clinician #3, Clinician #4, Staff #5, Staff #10, Partial Hospitalization (PH) Staff #11 and PH Staff #12) had training in the use of seclusion, physical restraint and isolation time out at least annually. Observation on 10/19/21 at 10:55 am of facility license with Crisis Services Director revealed: -The facility license was framed and hanging on	V 269		

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the rear wall of the nurses station.
-The license was effective 1/1/21 and shall expire 12/31/21.
-The facility is licensed for 4 programs including:
-27G.1100 Partial Hospitalization for Individuals who are acutely Mentally Ill Day program- 0 beds
- 27G.3100 Non-hospital Medical Detoxification Individuals who are Substance Abusers Residential program- 8 beds
- 27G.3300 Outpatient Detoxification for Substance Abuse Day program- 0 beds
- 27G.5000 Facility Based Crisis Service for Individuals of all Disability Groups Residential program-8 beds

Finding B:
Record review on 10/13/21 of computer generated current client census on 10/13/21 revealed:
-Facility Director had billing staff sort this client list; 13 clients, 10 of whom had primary diagnoses of Substance Use were highlighted yellow while 3 of the 10 also had co-occurring Mental Health diagnoses were noted in red. The remaining 3 clients only had mental health diagnoses were circled or noted in red.

Interview on 10/13/21 with Crisis Services Director revealed:
-They provided clinical services for clients with both mental health and substance use diagnoses.
-They did not bill for non-hospital medical detox as they served all clients under facility-based crisis.

Based on interviews with staff and record reviews, it could not be determined if Nonhospital Medical Detoxification was being provided independently of Facility Based Crisis Services. Additionally, staff could not be distinguished for

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V 269	Continued From page 6 each program. Review on 10/19/21 of Plan of Protection signed by the Crisis Services Director on 10/19/21 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? As per our license, we will only admit 8 consumers needing Facility Based Crisis Services and 8 consumers needing Non-Hospital Medical Detoxification. We will ensure the staffing of no less than to support staff , one for the 8-Non-Hospital Medical Detox consumers and one for the 8-Facility Based Crisis consumers. While on the unit consumers will be monitored according to our Monitoring Policy and procedure. At any time there is a behavioral crisis, staff will make every effort to deescalate the situation. Consumers may ask to go to their room or to a quieter area such as the Intake Area with staff supervising the consumer at all times. When the behavior cannot be deescalated and medical provider recommends a Time Out, staff will escort the consumer to the Intake area and one staff member will stay with the consumer. This Time Out must be documented as a Level II Incident and forwarded to [compliance personnel] to be entered into the State's Incident Response System. When a voluntary consumer requests to be discharged, the consumer will sign a Request for Discharge and the discharge will be staffed with the medical provider. If there is no clinical basis for Involuntary Commitment, the consumer shall be discharged. EBPI (Evidence Based Protective Intervention) Part II will be completed on Thursday, 10/21/2021. Describe your plans to make sure the above happens. The daily census will be monitored to ensure	V 269		

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admissions stay with the caps stated in our facility license.
The nurse on Duty will ensure support staff are applying our Monitoring Policy and Procedure when monitoring consumers which is they are monitoring the consumer's location and talking with the consumer to ascertain any behavioral issues.
At no time will a consumer, admitted to the facility, be taken off the unit because of behavioral issues without first attempting to de-escalate the behavior. The medical provider shall be contacted at this time to address any next steps. Crisis Services Director will be responsible for monitoring compliance."

This facility is licensed for 4 programs which serve adult clients who have a range of mental health and substance abuse disorders including but not limited to Schizoaffective Disorder, Cannabis Dependence, Major Depression, Bipolar Disorder with Psychotic Features, Opioid Dependence, Other Stimulant Dependence, Moderate Intellectual Developmental Disability and Alcohol Dependence. The facility was unable to maintain staff to client ratios that ensured the health and safety of the clients for two units and did not have separated program assignments in detox or crisis center. Staff provided direct care to clients without having been currently trained in the use of seclusion, physical restraint and isolation time-out. Former Client (FC) #7 had diagnoses of Alcohol Dependence, Major Depressive Disorder and a history of panic attacks. He was voluntarily admitted to the facility for alcohol detoxification and was served under the facility based crisis service. On the evening of 9/21/21 Nurse #2 and Clinician #4 were the only staff on duty at the facility. FC #7 became aggressive and disruptive which resulted in Nurse

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V 269	Continued From page 8 #2 calling law enforcement. When a local law enforcement officer arrived at the facility, FC #7 was removed from the milieu and taken to BHUCC (Behavioral Health Urgent Care Center)/Intake, a separate area of the building which is used to process clients being admitted. FC #7 remained isolated in the BHUCC/Intake area without staff monitoring for an unknown amount of time. There was no documentation of a restrictive intervention start time or end time. Staff failed to check the area for safety and FC #7 entered an office which had been left unlocked and he used the office phone to call 911 and reported that he was having chest pain. Staff were not aware of FC #7's situation until Emergency Medical Services (EMS) personnel arrived at the facility to transport him to a local hospital. The failure of the facility to recognize the significant treatment needs of the clients and adapt staffing to meet those needs constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $3,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 269		
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.	V 270		

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V 270	Continued From page 9 (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 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 record reviews and interviews the facility failed to provide additional staff to support more intensive supervision, treatment or management in response to the needs of individual clients. The findings are: Record review on 10/13/21 for FC #7 revealed: -Date of admission-9/20/21- voluntary for alcohol detoxification. -Diagnoses- alcohol dependence, uncomplicated; major depressive disorder, single episode, mild; history of panic disorder. -Discharge-9/22/21 AMA (against medical advice) -History-drank 12-17 glasses of wine daily. First	V 270		

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use as a teenager but had been a problem just the last 4 years. Currently prescribed Klonopin 1 milligram (mg) twice daily. Had history of liver complications and pulmonary hypertension. Breathalyzer at admission 0.242. ASAM (American Society of Addiction Medicine) III.7. Physician's recommendation dated 9/21/21 via telepsychiatry, noted to admit client to facility-based crisis.
-As per doctor's orders,15-minute safety checks for 24 hours were initiated at admission at 1:30pm on 9/20/21 and continued until 7:00pm on 9/21/21. Orders changed to 30-minute safety checks for 24 hours then 60-minute checks. Thirty-minute checks were documented from 7:30pm until 11:30pm on 9/21/21. The last 3 entries at 10:30pm, 11:00pm and 11:30pm by Clinician #4 noted FC #7 was in his room asleep. There was no additional documentation.

Review on 10/20/21 of hospital records for FC #7 dated 9/22/21 revealed:
"Patient is a 41-year-old male with past medical history of tachycardia, palpitations, anxiety on Klonopin who presents to emergency department from crisis center for evaluation. Per report from patient, he got into a verbal dispute with one of the staff members and they put him in a solitary room. Patient found (phone) by other room and called the police to be transported to hospital. He states that because they would not give him his nightly dose of Klonopin. Patient states he was there voluntarily. He denies any SI (suicidal ideation) or HI (homicidal ideation). Patient states that he really just there to help get him off of alcohol and tobacco. Patient has not drank anything in the last several weeks. Patient is predominately requesting a dose of his Klonopin and a cab ride home ...On arrival, patient is afebrile with normal vital signs. Patient is

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well-appearing in no acute distress. Patient is not have any signs of emergent pathology. Patient requests a dose of Klonopin to be given here, as his prescription is at the crisis center and will not be able to pick up until the morning. Patient will be given a one-time dose and discharged."

Review on 10/14/21 of personnel file for Nurse #2 revealed:
-Date of hire-9/7/21
-Registered Nurse (RN)

Review on 10/14/21 of personnel file for Clinician #4 revealed:
-Date of Hire-4/25/11
-Licensed Clinical Social Worker

Review on 10/13/21 of adverse event action report dated 9/22/21 completed by Nurse #2 revealed:
-"Consumer [FC #7] was placed in the back area just before midnight due to disruptive, threatening behavior, demanding behavior. Consumer located an office open used the phone to call EMS (Emergency medical services). EMS arrived [facility physician] allowed consumer to go to hospital with EMS. Consumer had tried to leave AMA (against medical advice) earlier in shift was told to wait until today but consumer did not want to wait."
-"Immediate actions taken: Due to client's loud, agitated behavior causing peers to awaken from sleep, interrupting peers rest, client was placed in BHUCC (Behavioral Health Urgent Care Center) per [facility psychiatrist] instructions to remain there until seen by MD in the am. Client located open office used phone to call EMS to come pick him up. EMS arrived informed nurse client had called complaining of chest pain and needed to be picked up. At 1:36am called on call

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psychiatrist reported client's action, on call psychiatrist instructed to allow client to go with EMS to be evaluated. Left with EMS at 1:40am."

Review on 10/15/21 of Clinician #4's service note dated 9/22/21 regarding FC #7 revealed: "Consumer had been acting aggressively all day, as was relayed to night shift staff by day shift during shift report. Consumer demanded to be released from facility and speak personally with the physician. He had a verbal altercation with the RN on duty in which he called her a b***h. He stated that he was to be given juice at any hour that he requested it and displayed an exaggerated sense of entitlement. He stated that if all of his demands were not met he would continuously hold the buzzer all night long. He stated that he intended to sue every employee of CCRC (Cleveland Crisis and Recovery Center) and that he was going to report all of the RNs to the NC (North Carolina) board of nursing. He was becoming increasingly verbally aggressive concerning leaving the facility immediately. RN on duty placed call to Facility Medical Staff Director [Medical Director], who advised due to it being so late in the evening, it would not be possible for the consumer to be discharged from the facility. [The Medical Director] advised that due to consumer's current level of agitation and aggression, he could be placed in the BHUCC (Behavioral Health Urgent Care Center) area along with the off-duty law enforcement in an attempt to keep him from disturbing the other consumers and causing further disturbance. Due to staff shortage, there was only one clinician and one RN on duty during the shift. Clinician had to carry out all the CSW (crisis support worker) duties as well as assisting a new staff RN with nursing documentation and processing an intake. This clinician was able to see the consumer in the

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V 270	Continued From page 13 BHUCC area on camera, although at times I had to take my eyes off the camera due to attending to other duties. At no time do I recall looking up and seeing that the consumer was not in the chair. However, in all honesty had I looked at the camera and seen that the consumer was NOT in the chair, this would not have immediately been a cause for alarm as I would have probably assumed the consumer was in the restroom. During the period of time that the consumer found one of the BHUCC office doors unlocked and used the office phone to place a call to 911, City of [local town] PD (police department) was ringing the doorbell with a voluntary consumer that they were asked by [local hospital] ED (emergency department) staff to transport here for possible admission. I was in the nursing station at this time, as the RN and the law enforcement officer had gone to the BHUCC area to assist with letting the voluntary consumer in. I was NOT able to go to the BHUCC area as I was the only remaining staff and was unable to leave the nursing station unattended. Almost simultaneously, multiple [local] Rescue EMT(emergency medical technicians)/paramedics were ringing the doorbell. As I was not yet aware that the consumer had placed a call to 911, I initially thought that it was law enforcement bringing another consumer to facility. After some time the law enforcement officer returned to the nurse's station to report the consumer had managed to go into one of the unlocked BHUCC offices and call 911. [The Medical Director] was contacted via phone call by RN on duty that the consumer had managed to call 911 and that he was now requesting to be transported to [local] ED with EMS (emergency medical services). [The Medical Director] stated that the consumer could leave the facility and be transported to the ED with EMS. It was later determined that the	V 270		

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consumer had been able to use the phone to call 911 because one of the BHUCC office doors had been unlocked. I was unaware that any of the BHUCC office doors were unlocked and admittedly did not check them prior to the consumer being placed in the BHUCC area, as my schedule thus far that evening had not permitted me to do so. Also, it is my understanding that when we have a consumer, whether voluntary or involuntary in the BHUCC holding area, if off-duty law enforcement is available, they are to remain in the BHUCC area so as to observe that person. Although we had a consumer being held in the BHUCC area, the on-duty law enforcement officer remained in the nurse's station and NOT in the BHUCC area with the consumer. I feel if the law enforcement officer had been more closely observing the consumer, perhaps this incident could have been avoided."

Review on 10/13/21 of Facility Director's investigative report dated 9/22/21 regarding the incident on 9/22/21 with FC #7 revealed:
-"Date of Admission: September 20,2021. Consumer arrived at Phoenix Counseling Center/Cleveland Crisis and Recovery at 1300 hours (1:00pm) at which time the triage and screening was initiated by a female Crisis Support Worker. This worker reported consumer asked why he was being asked all the questions during triage and screening and she informed him of the process and need to ask questions. As consumer awaited processing he and another consumer was watching the television in the Intake Area. The channel happened to be on [investigative television show] and consumer commented to the Deputy that the show was about murder and stated, 'Can you change the channel before I find a way to murder you' ...

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V 270	Continued From page 15 Consumer was admitted for alcohol detoxification but was not placed on any protocol because he had brought with him Clonazepam 1mg (milligram) take 1 bid (twice daily). He was also provided Nicorette Gum 4mg 1 piece every 2-4 hours PRN (as needed). Consumers were awoken at 0630 (6:30am) as usual on September 21, 2021 for vital signs, medications and breakfast meal. The night RN (registered nurse) administered Clonazepam 1mg to the consumer and offered him a 'cocktail' of multi adult gummies ORAL Chewable and B Complex Oral Tablet. Consumer refused these vitamins ...Later in the day, when vital signs were taken, consumers blood pressure was high. The RN offered clonidine and the consumer refused ...At 1900 hours (7:00pm) on 9/21/21, a Crisis Support Worker attempted to get consumer to attend AA (alcoholics anonymous) meeting in the dining room. Consumer refused to attend. During change of shift reporting at 2000 hours (8:00pm), both RN's were in the fishbowl (nurses station), when consumer started ringing the intercom several times ...At that time, this RN called Law Enforcement from the back and the officer took consumer to his room ...The night shift RN on 9/21/21 reported consumer continued his disruptive behavior. She described him as being loud and disturbing the milieu. A Crisis Support Worker verified the RN's report ...At med (medication) pass consumer refused his Clonazepam. At 2300 hours (11:00pm), the TV was turned off and consumer began getting loud, cursing and demanding that watching TV was the only way he could relax. RN offered him a cocktail of melatonin, trazadone and Vistaril but he refused. Consumer became so loud and disruptive, the RN called the law Enforcement officer from the back. After talking with [facility psychiatrist] the RN asked the officer to take the	V 270		

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consumer to the back until he could be discharged in the morning. After the officer's shift was over and no officer scheduled to work, the RN did go back to check on consumer and consumer blocked the door not allowing her to exit. He finally did let her leave. Consumer was then able to access a phone in an unlocked office and called 911. [Facility psychiatrist] was contacted and she agreed to let the consumer leave with EMS to the hospital."

Interview with FC #7 on 10/20/21 revealed:
-He had been treated unfairly at the facility by being locked in seclusion for 5 hours without staff monitoring. He was concerned for others who might not have a voice.

Attempts were made on 10/18/21 to contact Nurse #2 and Clinician #4 who had worked the overnight shift on 9/21/21 but neither returned calls.

Interview on 10/19/21 with Crisis Services Director revealed:
-"All of this could have been avoided if the RN had called me and I could have let her know that we could administratively discharge [FC #7] because was voluntary. [Nurse #2] maybe didn't know this. She is a contract nurse; temporary hire. Law enforcement officer left at 12 midnight. The officer is not staff and we are supposed to be supervising a client if they're back there. If staff are supervising via the monitor there are things they can't see. If a client is in the intake area, it requires staff round every 15 minutes. Staff are also required to ensure every door is locked. The CSW (crisis support worker) are responsible for this part. Basically, we didn't follow our safety and security protocol. It also falls on the RN since she is in charge. We made changes, effective

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September 20 (2021) to have a lead nurse here. Everything used to be supervised through [sister facility] and we started the practice of having a Lead CSW and Lead Nurse here. Our Clinical Manager started yesterday. We are trying to mitigate issues of being supervised by a different facility. The supervisor started competency check offs for the CSW. There is no policy for supervising a client in the back. That is considered a time out which can actually occur in their room but if they do a time out it always requires staff presence. [Nurse #2] has been instructed to call me from now on and I can give guidance on what's needed. [The lead nurse] was the lead nurse at the time. Staff called the on call physician and the on call physician did not want [FC #7] to leave until the next morning. That's generally when we discharge, however, he came in as voluntary and there was no reason to IVC (involuntarily commit) him. He had behaviors which were not related to psychosis. He had a way home. He calls him his Father, but it might have been his Grandfather. I met him when he returned to collect his possessions. The RN did call [facility psychiatrist] back that night when EMS arrived and [facility psychiatrist] agreed to let him go with EMS. We generally try to keep 2 CSW per shift. It's been difficult lately because we have been experiencing a staff shortage. We have been working on this. I didn't write about it in the internal investigation piece, but I informed staff to call me so I could advise them on what to do if there's ever an issue. We rarely have incidents here. We probably should not have admitted [FC #7]. Not sure if he met ASAM level to be here. He immediately had issues with the deputy. He may have met criteria. He was here for alcohol use and was wanting help. He threatened to murder the deputy over the tv. We only admit if a client meets 3.7 criteria and not

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V 270	Continued From page 18 hospital medical." This deficiency constitutes a recited deficiency and is cross referenced into 10A NCAC 27G.5001 Scope (V269) for a Type A1 rule violation and must be corrected within 23 days.	V 270		
V 518	27E .0104(e1-2) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (1) the requirement that positive and less restrictive alternatives are considered and attempted whenever possible prior to the use of more restrictive interventions; (2) consideration is given to the client's physical and psychological well-being before, during and after utilization of a restrictive intervention, including: (A) review of the client's health history or the client's comprehensive health assessment conducted upon admission to a facility. The health history or comprehensive health assessment shall include the identification of pre-existing medical conditions or any disabilities and limitations that would place the client at greater risk during the use of restrictive interventions; (B) continuous assessment and monitoring of the physical and psychological well- being of the client and the safe use of restraint throughout the duration of the restrictive intervention by staff who are physically present and trained in the use of emergency safety interventions;	V 518		

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V 518	Continued From page 19 (C) continuous monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being during the use of manual restraint; and (D) continued monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being for a minimum of 30 minutes subsequent to the termination of a restrictive intervention; This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to ensure staff were physically present to assess and monitor the physical and psychological well-being of the client throughout the duration of a restrictive intervention affecting 1 of 1 audited former client (Former Client (FC) #7). The findings are: Observation of the BHUCC (Behavioral Health Urgent Care Center)/Intake area and interview with Staff #5 on 10/14/21 at approximately 3:15 pm revealed: -An open room with 2 recliners, 1 chaise lounge chair and a mattress on the floor. -The room had concrete walls. -There were two ways to exit from the BHUCC/Intake area. -One exit was to go through two locked doors into the parking lot. -The other exit was to go through two locked doors into the crisis unit. -Staff would have to unlock the doors to allow a client access into and out of the BHUCC. Review on 10/13/21 of FC #7's record revealed:	V 518		

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V 518	Continued From page 20 -Date of Admission: 9/20/21. -Diagnoses: Alcohol Dependence, Uncomplicated; Major Depressive Disorder, Single Episode, Mild; History of Panic Disorder. -Discharged Against Medical Advice (AMA) on 9/22/21. Review on 10/14/21 of the Phoenix Counseling Center Policy and Procedure for Behavioral Management of Consumers revealed: -Policy: C. "Prohibited Behavioral Management Procedures 1. Under no circumstances shall the following prohibited procedures be authorized or used by PCC (Phoenix Counseling Center) Employees: ...k. Isolation outside of staff proximity ..." Review on 10/15/21 of Clinician #4's service note dated 9/22/21 regarding FC #7 revealed: -FC #7 had a verbal altercation with the Registered Nurse (RN) and became "increasingly verbally aggressive." -Staff contacted the Facility Medical Staff Director who "advised that due to consumer's current level of agitation and aggression, he (FC #7) could be placed in the BHUCC (former Behavioral Health Unit) area along with the off duty law enforcement in an attempt to keep him (FC #7) from disturbing the other consumers and causing further disturbance." -The facility was short staffed and one Clinician and one RN were the only staff on duty. -The Clinician was able to see FC #7 in the BHUCC area on camera, however she was unable to continuously monitor the camera because she had to perform other duties. -If she had looked at the camera and seen that FC #7 was not in the chair "this would not have immediately been cause for alarm" and she would have "assumed" FC #7 was in the	V 518		

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restroom.
-FC #7 found one of the BHUCC office doors unlocked and used the office phone to place a call to 911.
-Multiple Emergency Medical Technicians (EMTs)/Paramedics arrived at the facility.
-FC #7 requested to be transported to the local hospital emergency department via Emergency Medical Services (EMS).
-She "was unaware that any of the BHUCC office doors were unlocked and admittedly did not check them prior to the consumer being placed in the BHUCC area ...Also, it is my understanding that when we have a consumer, whether voluntarily or involuntarily in the BHUCC holding area, if off-duty law enforcement is available, they are to remain in the BHUCC area so as to observe that person. Although we had a consumer being held in the BHUCC area, the on duty law enforcement officer remained in the nurse's station and not in the BHUCC area with the consumer. I feel if the law enforcement officer had been more closely observing the consumer, perhaps this incident could have been avoided."

Review on 10/15/21 of Nurse #2's service note dated 9/21/21 regarding FC #7 revealed:
-FC #7 was "angry, belligerent, agitated ...argumentative, threatened staff ...refused to follow directions or redirections, demanding to be released ..."
-Staff contacted the on call psychiatrist for an AMA (against medical advice) release.
-Staff were instructed to hold FC #7 until the morning.
-"Due to clients loud, agitated behavior, causing peers to awaken from sleep, interrupting peers rest, client was placed in BHUCC per [Physician on Call] instructions to remain there until seen by MD (Medical Doctor) in the am."

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-FC #7 located an unlocked office and used the phone to call EMS to come pick him up.
-EMS arrived and informed the nurse FC #7 was complaining of chest pain.

Review on 10/14/21 of a facility complaint investigative report dated 9/22/21 revealed:
-The report was signed by the Crisis Services Director.
-The complaint was regarding the incident on 9/22/21 with FC #7.
-FC #7 was seen by the medical provider on 9/21/21 and reported he had a history of panic attacks.
-Later in the day, when vital signs were obtained, FC #7's blood pressure was high. FC #7 refused the medication offered by the RN.
-During the night shift on 9/21/21, the RN reported FC #7 was being loud and disturbing the milieu.
-At 11:00 pm FC #7 became so loud the RN called law enforcement.
-FC #7 asked to leave and staff informed him that he would have to wait for the doctor.
-FC #7 "stated that he got upset and because of that, he was put into seclusion for 4 hours. [FC #7] stated that the officer only stayed with him shortly and then left. He said no one came to check on him for several hours so he tried to escape. He said no one explained to him what was going on ...he escaped from an unlocked door - found a phone and called his Dad and 911 because he felt he was being held against his will."

Review on 10/15/21 of a Phoenix Counseling Center (PCC) Adverse Event report dated 9/22/21 completed by Nurse #2 revealed:
-Date of Event: 9/22/21.
-Time of Event: 1:36 am.

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V 518	Continued From page 23 -Type of Event: Restrictive Intervention. -Description of Event: "Consumer was placed in the back area just before MN (midnight) due to disruptive, threatening behavior, demanding behavior. Consumer located an office open used the phone to call EMS. EMS arrived [Physician on Call] allowed consumer to go to hospital with EMS ..." Interview with FC #7 on 10/20/21 revealed: -He had been treated unfairly at the facility by being locked in seclusion for 5 hours without staff monitoring. He was concerned for others who might not have a voice. Attempts were also made on 10/18/21 to contact Nurse #2 and Clinician #4 who had worked the overnight shift on 9/21/21 but neither returned calls. Interview on 10/19/21 with the Crisis Services Director revealed: -There was a conflict between FC #7 and the RN. -The RN contacted law enforcement and the law enforcement officer took FC #7 "to the back" (BHUCC/Intake area). -He stated, "Clients generally don't get moved to the back unless we are preparing for discharge. Once the RN sent the client to the back, it became an incident and we had to have a report because you're basically taking the client off the unit." -The law enforcement officer left the facility at midnight. -"Law enforcement officers are not staff and we are supposed to be supervising a client if they're back there. If staff are supervising via the monitor, there are things they can't see." -Staff were required to ensure that every door was locked.	V 518		

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V 518	Continued From page 24 -He stated, "Basically we didn't follow our safety and security protocol." -The incident with FC #7 was considered a "time out" which always requires staff presence. -The facility had been experiencing a staff shortage. This deficiency is cross referenced into 10A NCAC 27G.5001 Scope (V269) for a Type A1 rule violation and must be corrected within 23 days.	V 518		
V 521	27E .0104(e9) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (9) Whenever a restrictive intervention is utilized, documentation shall be made in the client record to include, at a minimum: (A) notation of the client's physical and psychological well-being; (B) notation of the frequency, intensity and duration of the behavior which led to the intervention, and any precipitating circumstance contributing to the onset of the behavior; (C) the rationale for the use of the intervention, the positive or less restrictive interventions considered and used and the inadequacy of less restrictive intervention techniques that were used; (D) a description of the intervention and the date, time and duration of its use; (E) a description of accompanying positive methods of intervention; (F) a description of the debriefing and planning with the client and the legally responsible person,	V 521		

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V 521	Continued From page 25 if applicable, for the emergency use of seclusion, physical restraint or isolation time-out to eliminate or reduce the probability of the future use of restrictive interventions; (G) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the planned use of seclusion, physical restraint or isolation time-out, if determined to be clinically necessary; and (H) signature and title of the facility employee who initiated, and of the employee who further authorized, the use of the intervention. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure the required documentation was in the client record when a restrictive intervention was utilized affecting 1 of 1 audited former client (FC #7). The findings are: Refer to tag V518 for specific information about the restrictive intervention. Review on 10/14/21 and 10/15/21 of facility records revealed: -There was no documentation of the description of the intervention and the date, time and duration of its use. -No notation of FC #7's physical and psychological well-being. -No documentation of the signature and title of the facility employee who initiated, and of the employee who further authorized the use of the intervention. Interview on 10/19/21 with the Crisis Services Director revealed: -The facility used to be directly supervised by staff	V 521		

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V 521	Continued From page 26 whose main office was located in another local county. -He stated, "We are trying to mitigate issues of being supervised by a different facility ...We started the practice of having a Lead CSW (Crisis Support Worker) and Lead Nurse here." -A new Clinical Manager started working effective 10/18/21. -The Supervisor started competency "check-offs" for all of the CSWs. This deficiency is cross referenced into 10A NCAC 27G.5001 Scope (V269) for a Type A1 rule violation and must be corrected within 23 days.	V 521		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is	V 537		

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V 537	Continued From page 27 demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures.	V 537		

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V 537	Continued From page 28 (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course;	V 537		

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V 537	Continued From page 29 (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers.	V 537		

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This Rule is not met as evidenced by:
Based on record reviews and interview, the facility failed to ensure 7 of 7 audited staff (Nurse #2, Clinician #3, Clinician #4, Staff #5, Staff #10, Partial Hospitalization (PH) Staff #11 and PH Staff #12) had training in the use of seclusion, physical restraint and isolation time out at least annually. The findings are:

Review on 10/14/21 of the Phoenix Counseling Center Policy and Procedure for Behavioral Management of Consumers revealed:
-Policy: A. " ...In maintaining a therapeutic environment, all employees shall have specialized training and demonstrate competencies to serve consumers in the least restrictive manner possible, to include the use of emergency restrictive intervention procedures ..."
-It was signed by the Board Chair and the Chief Executive Officer (CEO) on 4/21/21.

Review on 10/14/21 of Nurse #2's record revealed:
-Date of Hire: 9/7/21.
-No training in the use of seclusion, physical restraint and isolation time out.

Review on 10/14/21 of Clinician #3's record revealed:
-Date of Hire: 8/3/20.
-No training in the use of seclusion, physical restraint and isolation time out.

Review on 10/15/21 of Clinician #4's record revealed:
-Date of Hire: 4/25/11.

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V 537	Continued From page 31 -No training in the use of seclusion, physical restraint and isolation time out. Review on 10/14/21 of Staff #5's record revealed: -Date of Hire: 7/15/13. -No current training in the use of seclusion, physical restraint and isolation time out. Review on 10/14/21 of Staff #10's record revealed: -Date of Hire: 4/4/16. -No current training in the use of seclusion, physical restraint and isolation time out. Review on 10/14/21 of PH Staff #11's record revealed: -Date of Hire: 8/25/14. -No current training in the use of seclusion, physical restraint and isolation time out. Review on 10/14/21 of PH Staff #12's record revealed: -Date of Hire: 9/6/16. -No current training in the use of seclusion, physical restraint and isolation time out. Review on 10/14/21 of the Local Management Entity-Managed Care Organization (LME-MCO) Bulletin #J368 dated 7/6/20 revealed: -" ...Existing certification currently held by individuals may be extended and deemed valid through September 30, 2020 to allow additional time for renewal of certifications considering the unprecedented circumstances of the COVID-19 public health emergency and to prevent a lapse in certification. Such extensions apply only to individuals who are already certified and whose certification would otherwise be due for renewal before September 30, 2020 ..."	V 537		

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V 537	Continued From page 32 Interview on 10/14/21 with the Human Resource Director revealed: -Staff were always trained in EBPI prevention and base plus prior to COVID-19. -Staff had only been trained in the prevention portion of EBPI because of COVID-19. -She was not aware that the extensions for training in seclusion, physical restraint and isolation time out had expired on 9/30/20. This deficiency is cross referenced into 10A NCAC 27G.5001 Scope (V269) for a Type A1 rule violation and must be corrected within 23 days.	V 537		