STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601361	A. BUILDING: _____ B. WING _____	R 02/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SECU YOUTH CRISIS CENTER, A MONARCH PROGR	1810 BACK CREEK DRIVE CHARLOTTE, NC 28213

(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 000	INITIAL COMMENTS A follow up survey was completed on 2-8-22. Deficiences were cited. This facility is licensed for the following service categories: 10A NCAC 27G .3100 Nonhospital Medical Detoxification for Individuals who Are Substances Abusers, 10A NCAC 27G .5000 Facility Based Crisis Service for Individuals of All Disability Groups The survey sample consisted of three former clients.	V 000		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based	V 109		

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V 109	Continued From page 1 employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record review and interview one of one Qualified Professional (QP#1) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are: Review on 2-8-22 of QP#1's personnel record revealed: -Was working as a Case Manager for the facility Trainings include: Calming Children in Crisis 5-14-21, Rights Orientation 5-4-21, Cultural Competency 5-4-21, CPI for Facility Based Crisis Programs 5-7-21. Review on 2-8-22 of internal investigation dated 2-3-22 and signed by the Director of Youth Crisis Service revealed: -"[QP#1] entered the milieu to meet with patient and discuss the recommended level of care. Due to efforts made to identify a higher level of care, [QP#1] encouraged the patient to	V 109		

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sign the required intake packet."

-"During the conversation, patient sniffed. At that time, [QP#1] inquired about where her mask was since she had tested positive for COVID the previous week. [QP#1] also made mention that due to the exposure, staff were required to take rapid tests every five days."

-"Patient (Client #1) reported that due to her no longer being contagious following the 5 days after her first reported symptom, she was not required to wear the mask at this point per medical director."

-"[QP#1] redirected her again to put on the mask and commented that he saw it in her pocket; this was after the second directive."

-"Patient became agitated and proceeded to get up from the table. After being redirected to sign the referral/ intake packet, she picked up the pen provided by [QP#1] and threw it on the floor causing it to break."

-"Per staff report, [QP#1] became frustrated and made a comment to the effect of "forget it then" regarding the patient signing the packet."

-"Per staff report, [QP#1] proceeded to walk away. While doing so, he made the following comment, "go sit your retarded a*s down." ([QP#1's] report stated that he used "restarted self" just fyi (for your information)).

-"Following the statement made from [QP#1], the patient charged towards him with clinched fists making statements such as, "I'm going to f** k you up", "let's go,", "your bald- headed ass ..." etc."

-"Per staff report, [QP#1] and the patient continued to make statements back and forth to each other as voices were raised."

-"[QP#1] eventually exited the milieu and remained at the front of building in his office."

-"Following the incident, the director was notified by [QP#1] that he had completed the

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incident report

-"Director was also notified by multiple staff on the incident that had occurred

-"Following the knowledge of the incident, the director entered the milieu to ensure that the patient was calm and proceeded to obtain her statement

-Conclusion: "The verbal interaction between [QP#1] and the patient was not conducted in a therapeutic manner. [QP#1] was inappropriate with his responses and made little to no attempts to defuse the situation after patient started to get triggered and agitated. Implementation of verbal de-escalation techniques and re-training on trauma informed care is necessary to maintain the level of care expected by staff at the youth crisis facility."

Review on 2-8-22 of North Carolina Incident Response Improvement System incident on 2-1-22 revealed:

-"During the afternoon of 2/1/22, the case manager entered the milieu requesting the patient to sign the intake packet for a potential placement. Due to the patient ' s positive COVID test result from the previous week, the case manager questioned the patient as to why she was not wearing her mask, and asked where it was. Patient reported that since it had been at least five days since her initial exposure, she was not being required to wear the mask per after care directives from the PCR (polymerase chain reaction) test and recommendations from the medical director. Case manager reported to the patient that due to the positive test results, staff were being required by the HR (Human Resources)COVID team to test every 5 days for the next week. Case manager provided another directive for patient to put on her mask. At this time, patient became agitated, took the case

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manager ' s pen, and threw it on the floor breaking his pen. Patient then started yelling and screaming profanities at the case manager. Patient proceeded to walk towards the case manger with clinched fists while being prompted to stop from the behavioral technician and occupational therapist. Case manager also prompted the patient to stop and "back up" as the patient proceeded to follow the case manager while attempting to leave the milieu. As the case manager continued to walk away, the patient continued to yell swear words directed at him. The case manager stated, "you better get (or stay) back with your retarted self." At that time, other staff continued to intervene and direct the patient away from the case manager is an effort to de-escalate the interaction. Patient continued to name call and use racial slurs to case manager, and even made a threat to "f**k him up." The patient eventually complied with returning to the table on the milieu in an effort to calm down and process with staff."

Interview on 2-8-22 with two unidentified staff revealed:

-" He (QP#1) said we aren't going to finish this (placement) he started walking away."

-"[Client #1] charged at him and he said sit your retarded ass down."

-"Thankfully [Client #1] has a really good relationship with us. We processed with her, she had no behaviors. She said that word was a trigger. But we all agreed it was not acceptable.

-"I had heard it happen. I heard raised voices. But I thought it was the training in the next room."

-"She (Client #1) talked about how it upset her particularly the word retard, her uncle called her that and it was hurtful to her."

-" She (Client #1) went back to her activities."

-It might not be productive to interview Client

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V 109	Continued From page 5 #1 as it might upset her to talk about the incident again. Interview on 2-8-22 with the Vice President of Operations Crisis Services revealed: -The QP#1 was working as a case manager but he had QP qualifications. -He had been an "exemplary" employee for the facility. -The investigation had not been completely closed yet and the QP#1 had been advised not to talk to anyone about the incident. -They were recommending that he receive more training and get written disciplinary notice. -Interactions such as the one between QP#1 and Client #1 were not tolerated at the facility.	V 109		