STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-171	A. BUILDING: _____ B. WING _____	R 02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND CRISIS AND RECOVERY CENTEF	609 NORTH WASHINGTON STREET SHELBY, NC 28150

(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 February 25, 2022. Deficiencies were cited. This facility is licensed for the following service categories: 10A NCAC 27G.1100 Partial Hospitalization for Individuals who are acutely Mentally Ill, 10A NCAC 27G.3100 Non-Hospital Medical Detoxification for Individuals who are Substance Abusers, 10A NCAC 27G.3300 Outpatient Detoxification for Substance Abuse, 10A NCAC 27G.5000 Facility Based Crisis Service for Individuals of all Disability Groups. The survey sample consisted of audits of 6 current clients, 1 former client and 1 deceased client.	V 000		
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 record reviews, interviews, and	V 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-171	A. BUILDING: _____ B. WING _____	R 02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND CRISIS AND RECOVERY CENTEF	609 NORTH WASHINGTON STREET SHELBY, NC 28150

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V 269	Continued From page 1 observations, 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: CROSS REFERENCE: 10A NCAC 27G.5002 Staff (V270). Based on record reviews, observation 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 affecting 1 of 1 Former Client (FC #7). CROSS REFERENCE: 10A NCAC 27G.5003 Operations (V271). Based on record reviews, observation and interviews, the facility failed to implement protocols and procedures for assessment, treatment, and monitoring affecting 1 of 1 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 interviews, the facility failed to ensure 6 of 6 audited staff (Clinical Manager, Registered Nurse (RN) #1, Clinician #2, Staff #6, Staff #7 and Staff #8) had training in the use of seclusion, physical restraint and isolation time out at least annually. Review on 1/12/22 of the facility license revealed: -The license was effective 1/1/22 and shall expire 1/31/22. -The facility was licensed for the following programs: -27G.1100 Partial Hospitalization for Individuals who are acutely Mentally Ill Day Program- 0 beds; -27G.3100 Non-hospital Medical Detoxification for Individuals who are Substance Abusers	V 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-171	A. BUILDING: _____ B. WING _____	R 02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND CRISIS AND RECOVERY CENTEF	609 NORTH WASHINGTON STREET SHELBY, NC 28150

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V 269	Continued From page 2 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. -Capacity: 16. Interview on 1/12/22 with the Facility Director revealed: -The Outpatient Detoxification for Substance Abuse program and the Partial Hospitalization for Individuals who are acutely Mentally Ill were no longer serving clients at this time due to limited attendance. -The only services currently provided at the facility were the two residential programs (Facility Based Crisis and Non-hospital Medical Detoxification). Review on 1/28/22 of a Plan of Protection completed and signed by the Facility Director on 1/28/22 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? A direct care staff member will be assigned to stay in the Intake area with any consumer waiting to be admitted to the unit. If a consumer is placed in Isolation/Time Out, a direct care staff will be assigned to stay with and monitor the consumer. This direct care staff cannot be part of the unit rotation. Describe your plans to make sure the above happens. Direct Care staff initially had an office in the Intake Area. This will be reversed and direct care staff, separate from the unit staff, will remain in the Intake Area." Review on 1/31/22 of a 2nd Plan of Protection	V 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-171	A. BUILDING: _____ B. WING _____	R 02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND CRISIS AND RECOVERY CENTEF	609 NORTH WASHINGTON STREET SHELBY, NC 28150

(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 269	Continued From page 3	V 269		

completed and signed by the Facility Director on 1/29/22 revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care? A direct care staff member will be assigned to stay in the Intake area with any consumer waiting to be admitted to the unit. If a consumer is placed in Isolation/Time Out, a direct care staff will be assigned to stay with and monitor the consumer. This direct care staff cannot be part of the unit rotation.
Describe your plans to make sure the above happens.
Direct Care staff initially had an office in the Intake Area. This will be reversed and direct care staff, separate from the unit staff, will remain in the Intake Area. The Facility Director, Clinical Manager, and Lead Nurse will work together to ensure a direct care staff is assigned to the Intake Area whenever a consumer is present. This direct care staff person cannot taken be taken from the unit ratio required to monitor unit consumers."

Review on 2/25/22 of a 3rd Plan of Protection completed and signed by the Facility Director on 2/25/22 revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care? Any consumer who enters the Intake Area will have a Health Screening Form, which would include taking of vital signs, completed as part of the Triage and Screening process. At any time, the consumer has a blood pressure of > 170/100 or < 90/60 or pulse > 110 persistently > 130, the nurse on duty will contact the medical provider to determine if the consumer needs to go to the Emergency Department or treated with Clonidine. Vital Signs will continue to be monitored while awaiting the arrival of EMS or following the taking

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-171	A. BUILDING: _____ B. WING _____	R 02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND CRISIS AND RECOVERY CENTEF	609 NORTH WASHINGTON STREET SHELBY, NC 28150

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V 269	Continued From page 4	V 269		

of the Clonidine. If Clonidine does not lower the blood pressure, the medical provider will be contacted and consumer will be referred to the Emergency Department.
Describe your plans to make sure the above happens.
The above actions will be written as an Intake protocol and vitals will be documented on a Vital Sign Sheet. Consumer will be monitored by staff assigned to the intake Area."

This facility is licensed for 2 day treatment programs and 2 residential programs. The 2 residential programs were the only services being provided by the facility which served clients who have a range of mental health and substance abuse disorders including but not limited to Bipolar Disorder; Paranoid Schizophrenia; Other Stimulant-Induced Psychotic Disorder with Hallucinations; Alcohol Dependence; Post Traumatic Stress Disorder; Cannabis Dependence; Opioid Use Disorder; Methamphetamine Use Disorder and Major Depressive Disorder. FC #7 resided in a group home and had diagnoses of Bipolar Disorder and Paranoid Schizophrenia along with a history of attempting to harm others and expressing a desire to self-harm. FC #7 was under the influence of alcohol when he arrived at the crisis center and he also had a blood pressure reading of 183/111. FC #7 remained isolated in the intake area from 8:00 pm on 1/9/22 through 11:30 am on 1/10/22. There was no evidence that FC #7 had been medically cleared and there was no evidence that his blood pressure was treated or re-checked. The facility was unable to maintain staff to client ratios that ensured the health and safety of the clients. When the facility reached the 16 bed maximum capacity for which they were licensed, staff continued to accept clients into the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-171	A. BUILDING: _____ B. WING _____	R 02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND CRISIS AND RECOVERY CENTEF	609 NORTH WASHINGTON STREET SHELBY, NC 28150

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V 269	Continued From page 5 intake area. There was no known limit as to how many clients could be in the intake area at one time. Staff were responsible for performing screening assessments, obtaining vital signs, conducting safety checks, medicating and providing interventions to the clients in the intake area in addition to providing care for the 16 clients who already had a bed assignment on the unit. Furthermore, staff provided direct care to clients without having been currently trained in the use of seclusion, physical restraint and isolation time-out. Clients could not freely exit the intake area as all exit doors automatically locked. Clients were left isolated and un-monitored in the intake area outside of staff proximity for unknown periods of time. Additionally, due to the lack of documentation and record keeping by facility staff, it could not be determined how many clients had been held in the intake area or for what length of time they were there. This deficiency constitutes a Failure to Correct the Type A1 rule violation originally cited for serious neglect. An administrative penalty of $500.00 per day is imposed for failure to correct within 23 days.	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. (c) The facility shall have the capacity to bring additional staff on site to provide more intensive supervision, treatment, or management in	V 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-171	A. BUILDING: _____ B. WING _____	R 02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 270	Continued From page 6 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, observation 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 affecting 1 of 1 Former Client (FC #7). The findings are: Review on 1/18/22 of Former Client (FC) #7's record revealed: -Date of Admission: 1/9/22. -Diagnoses: Bipolar Disorder and Paranoid Schizophrenia. -Date of Discharge: 1/10/22. -A Phoenix Counseling Center (Licensee) Triage Medical Clearance Form for FC #7 dated 1/9/22 indicated: -There was no evidence that FC #7	V 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-171	A. BUILDING: _____ B. WING _____	R 02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND CRISIS AND RECOVERY CENTEF	609 NORTH WASHINGTON STREET SHELBY, NC 28150

(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 270	Continued From page 7	V 270		

had been medically cleared.
-A Crisis Assessment dated 1/9/22 indicated: FC #7 resided in a group home; had a fixed delusion that he was in the military and during the assessment screening, FC #7 "repeatedly asked to call the guards and Green Berets."; FC #7 also had a history of attempting to harm others and a history of expressing the desire to self-harm.

Review on 1/18/22 of a Level of Care Utilization (LOCUS) Worksheet for FC #7 dated 1/9/22 revealed:
-Risk of Harm: risk severity rating of 3/Moderate.
-Functional Status: risk severity rating of 4/serious impairment.

Observation on 1-12-22 at approximately 10:55 am of the Intake Area/Former Behavioral Health Urgent Care Center (BHUCC) revealed:
-An open room with 2 recliners.
-The room had concrete walls.
-There were two ways to exit from the 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.
-The exit doors locked automatically.
-There was no way to freely enter or exit the area without a key/staff identification badge.

Review on 1/18/22 of the Phoenix Counseling Center Patient Safety Rounds Sheets for FC #7 dated 1/9/22 and 1/10/22 revealed:
-FC #7 remained in the back intake area from 8:00 pm on 1/9/22 through 11:30 am on 1/10/22.
-Staff completed safety rounds on FC #7 every 15 minutes during this time frame.

Efforts were made on 1/31/22, 2/2/22 and 2/3/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-171	A. BUILDING: _____ B. WING _____	R 02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND CRISIS AND RECOVERY CENTEF	609 NORTH WASHINGTON STREET SHELBY, NC 28150

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V 270	Continued From page 8 to interview FC #7. Phone calls were not returned Interview on 1/12/22 with the Clinical Manager revealed: -If the facility had reached maximum capacity, clients could spend the night in the intake area and then get admitted in the morning if there was an anticipated discharge. -Staff were required to perform safety rounds on the clients in the intake area. -Nurses would get orders to medicate unstable clients that were in the intake area in order to assist with safety. Interview on 1/12/22 with Clinician #2 revealed: -If the facility was at maximum capacity and a client arrived for intake, they would be assessed and referred for appropriate placement. -Sometimes it would take a couple of days to find placement for a client. -She did not know if there was a maximum number of clients that could be held in the back intake area. -She thought it might be based on the acuity level of the clients. -" ...There is a Clinician, CSW (Crisis Support Worker) and medical staff person working the unit on every shift and all 3 of those people would share in the responsibility of monitoring the people in the back. If people have to be back there (in the intake area) because there is no beds then the CSW, nursing and/or Clinician must check on them to see if they are ok." Interview on 2/2/22 with the Lead Nurse revealed: -" ...[FC #7] was in the intake area and as the nurse I was busy on the unit and I only went back there to check on him once ..." Interview on 1/19/22 with RN #1 revealed:	V 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-171	A. BUILDING: _____ B. WING _____	R 02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND CRISIS AND RECOVERY CENTEF	609 NORTH WASHINGTON STREET SHELBY, NC 28150

(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 270	Continued From page 9	V 270		

-" ...If we are already full and we allow a consumer in the back (intake area) we may not have enough people to cover the back ... In the case that we have enough staff to monitor them, we might keep them (clients) in the back if a bed is available the next morning. We try to maintain a safe staff to patient ratio. If a consumer is in the back they will be rounded on by staff and it's usually at least every 15 minutes ..."

Interview on 1/12/22 and 1/31/22 with Staff #6 revealed:
-If clients came to the facility when there were no beds available, staff would still "bring them (clients) in and do an assessment."
-If there was a discharge coming up, staff could place clients in "observation" and keep them safe until a bed was available.
-If there was not an anticipated discharge then clients could stay in the intake area on the lounge chairs, or a mattress.
-All of the doors to the intake area were locked and staff used a keypad to enter the area.
-She stated, "We need more staff. It's hard to handle both places (inpatient unit and intake area) ...There's no limit how many people can come to the door ..."
-Staff were required to process intakes, complete safety rounds, obtain vital signs, and pick up food for clients from a local restaurant.

Interview on 1/13/22 with Staff #8 revealed:
-His main responsibility was to "basically work solely in the intake area."
-His work hours were usually 9 am to 5 pm on weekdays.
-If the facility was at full capacity, clients would stay in the intake area until a bed became available.
-Staff would complete safety checks on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-171	A. BUILDING: _____ B. WING _____	R 02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND CRISIS AND RECOVERY CENTEF	609 NORTH WASHINGTON STREET SHELBY, NC 28150

(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 270	Continued From page 10	V 270		

clients in the intake area that were waiting on a bed.
-He never encountered a time when a client was "held in the intake unit" and was not able to be admitted.
-He stated, "If I am not present in the intake area, we would call the on-call staff to come in and monitor the back ...We try to work them (clients) all in. We don't want to turn people away that need help."
-He believed the maximum capacity of the intake area was 5 clients because he never knew more than that to be there.
-A police officer was usually present in the intake area "sometimes during the day and sometimes at night or on weekends."
-Police officers were not staff members of Cleveland Crisis and Recovery Center.

Interview on 1/12/22 with Staff #7 revealed:
-" ...When a client comes in, a rounds sheet is brought from the back (intake area) to let us know that someone is back there and it's up to whoever grabs it. It will go to the staff member that has the least amount of clients ... I don't really know the number of people that are allowed to stay back there (intake area). I believe we have to assess everyone that comes to the door so I wouldn't put a number on that..."
-Clients were not assigned a room number until they were on the unit.
-Clients in the intake area were treated the same as if they were on the unit.
-Staff were required to check on clients in the intake area every 15 minutes.
-He would "bring snacks to them and ask them if they are alright."
-Clients in the intake area were considered to be assigned to the BHUCC.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-171	A. BUILDING: _____ B. WING _____	R 02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND CRISIS AND RECOVERY CENTEF	609 NORTH WASHINGTON STREET SHELBY, NC 28150

(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 270	Continued From page 11 Interview with the Facility Director on 1/19/22 revealed: -BHUCC had not been in service for 3 years. -There was no way to track clients who were assessed in the intake area and not admitted. -He stated, "We haven;t collected information on clients back there (intake area) ever since BHUCC stopped. -When the BHUCC was operating it was a requirement for all clients to be tracked from the beginning to the end of service. -Facility staff would start tracking clients again this week. Review on 1/31/22 of an email dated 1/31/21 from the Facility Director to a Division of Health Service Regulation (DHSR) Surveyor revealed: -"...I informed you in one of our meetings that we haven't tracked Intake data since we stopped being a BHUCC. The truth of the matter is I still had a clinician gather that information, if my memory serves me right, through July 2021 until changes were made in what we call the 'Admission Packet.' I have re-started the collection of the Intake Data..." Efforts were made on 2/1/22 and 2/2/22 to interview Clinician #3 and an unaudited CSW. Phone calls were not returned. Due to the lack of documentation, it could not be determined how many clients were held in the intake area and if their treatment needs were being met. This deficiency is cross referenced into 10A NCAC 27G.5001 Scope (V269) for a Failure to Correct Type A1 rule violation.	V 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-171	A. BUILDING: _____ B. WING _____	R 02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND CRISIS AND RECOVERY CENTEF	609 NORTH WASHINGTON STREET SHELBY, NC 28150

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V 271	Continued From page 12	V 271		
V 271	27G .5003 Facility Based Crisis - Operations 10A NCAC 27G .5003 OPERATIONS (a) Each facility shall have protocols and procedures for assessment, treatment, monitoring, and discharge planning for adults and for children of each disability group served in the facility. Protocols and procedures shall be approved by the area program's medical director or the medical director's designee, as well as the director of the appropriate disability unit of the area program. (b) Discharge Planning and Referral to Treatment/Rehabilitation Facility. Each facility shall complete a discharge plan for each client that summarizes the reason for admission, intervention provided, recommendations for follow-up, and referral to an outpatient or day program or residential treatment/rehabilitation facility. This Rule is not met as evidenced by: Based on record reviews, observation and interviews, the facility failed to implement protocols and procedures for assessment, treatment, and monitoring affecting 1 of 1 Former Client (FC #7). The findings are: Observation on 1-12-22 at approximately 10:55 am of the Intake Area/Former Behavioral Health Urgent Care Center (BHUCC) revealed: -There were two ways to exit from the 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. -The exit doors locked automatically.	V 271		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-171	A. BUILDING: _____ B. WING _____	R 02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND CRISIS AND RECOVERY CENTEF	609 NORTH WASHINGTON STREET SHELBY, NC 28150

(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 271	Continued From page 13 -There was no way to freely enter or exit the area without a key/staff identification badge. Review on 1/18/22 of Former Client (FC) #7's record revealed: -Date of Admission: 1/9/22. -Diagnoses: Bipolar Disorder and Paranoid Schizophrenia. -Date of Discharge: 1/10/22. -There was no Medication Administration Record (MAR) to indicate whether FC #7 received any medication. Review on 1/18/22 of a Phoenix Counseling Center (Licensee) Initial Screening /Triage /Referral Form for FC #7 dated 1/9/22 revealed: -Presenting Problem: FC #7 " ...needed a ride to CCRC (Cleveland Crisis and Recovery Center) because he needed his psychotropic meds (medications) adjusted ..." -Major Illness/Disease: Diabetes. -Substance Abuse: "Currently under influence? Yes..." Review on 1/18/22 of the Crisis Assessment for FC #7 dated 1/9/22 revealed: -FC #7 resided in a group home. -FC #7 has a history of expressing the desire to self-harm. -"Group home administrator states that the consumer (FC #7) did try to attack one of the group home residents in the past ..." -FC #7 "reported that currently he does take medications for his Bipolar but stated that he could not recall what the medications were ..." -Group home staff reported FC #7 had been "cheeking his meds" and "declining rapidly ..." Review on 1/18/22 of a Phoenix Counseling Center Triage Medical Clearance Form dated	V 271		

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	MHL023-171	A. BUILDING: _____ B. WING _____	R 02/25/2022

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V 271	Continued From page 14 1/9/22 revealed: -The following assessment sections of the form had not been completed and were left completely blank: -Known Medical Conditions/History/Family History; -Medical Devices/Activities of Daily Living (ADL's); -Comments; -Current Medications Including Medical /Psychiatric /Herbal/Over the Counter; -Allergies; -The section labeled "Disposition and Reason If Not Cleared" had an option to check either Cleared by a Registered Nurse (RN), Referred to Emergency Room (ER), or Emergency Medical Services (EMS) Contacted. None of the options were checked. -At the bottom of the form in bold capital letters were the following instructions: "STAFF NOTIFY RN IMMEDIATELY OF ANY OF THE FOLLOWING" which included any consumer with a history of violence, or a blood pressure greater than 160/90. -FC #7 had a blood pressure reading of 183/111 on 1/9/22 at 8:30 pm. -There was no evidence in FC #7's record to indicate that his blood pressure was ever rechecked or treated by staff. -There was no signature by an RN, or any other staff to indicate that FC #7 had been medically cleared. Review on 1/18/22 of the Phoenix Counseling Center Patient Safety Rounds Sheets for FC #7 dated 1/9/22 and 1/10/22 revealed: -FC #7 remained in the back intake area from 8:00 pm on 1/9/22 through 11:30 am on 1/10/22. Interview on 2/25/22 with the Facility Director	V 271		

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V 271	Continued From page 15 revealed: -"If a blood pressure is that high (183/111), we would usually send them (clients) to the ER." Interview on 1/12/22 wit the Clinical Manager revealed: -"...We can no longer leave them (clients) in the back (intake area) because staff would have to be back there at all times to check on them..." -If the facility was at maximum capacity and a discharge was anticipated the following day then staff would allow clients to sleep in the intake area overnight. -FC #7 was "psychotic and unstable...he was too acute for the unit..." -FC #7 spent the night in the intake area. Interview on 2/2/22 with the Lead Nurse revealed: -FC #7 "was in the intake area and as the nurse I was busy on the unit and I only went back there to check on him once ...I want to say that an officer was back there in the officer area, but as far as phoenix staff, no they weren't with him ..." Interview on 1/12/22 and 1/31/22 with Staff #6 revealed: -She could not "remember who, if anyone" was in the intake area with FC #7. Efforts were made on 1/31/22, 2/2/22 and 2/3/22 to interview FC #7. Phone calls were not returned. Efforts were made on 2/1/22 and 2/2/22 to interview Clinician #3 and an unaudited Crisis Support Worker (CSW). Phone calls were not returned. This deficiency is cross referenced into 10A NCAC 27G.5001 Scope (V269) for a Failure to	V 271		

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V 271	Continued From page 16 Correct Type A1 rule violation.	V 271		
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; (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	V 367		

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V 367	Continued From page 17 (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 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	V 367		

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V 367	Continued From page 18 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 record reviews and interviews, the facility failed to submit an updated report to all required report recipients by the end of the next business day whenever information provided in the report may be erroneous, misleading, or otherwise unreliable. The findings are: Review on 1/25/22 of Deceased Client (DC) #8's record revealed: -Date of Admission: 12/20/21. -Diagnoses: Opioid Dependence with Opioid Induced Psychotic Disorder with Hallucinations; Cannabis Dependence, Uncomplicated; Cocaine Abuse, Uncomplicated; Sedative Hypnotic, Anxiolytic Abuse, Uncomplicated. -Date of Discharge: 12/23/21. -Date of Death: 12/24/21. -Initial Screening/Triage/Referral Form dated 12/20/21 indicated Major Illness/Disease: Traumatic Brain Injury (TBI); Consumer currently using Fentanyl, Cocaine, Benzodiazepines, and Tetrahydrocannabinol (THC); Consumer reports suicidal ideation (SI). -Crisis Assessment dated 12/20/21 indicated: history of TBI; under Involuntary Commitment Petition (IVC) due to consumer having SI; urine	V 367		

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V 367	Continued From page 19	V 367		

drug screen positive for Cocaine, Benzodiazepines, and THC; Consumer has high risk of relapse.
-Person-Centered Profile (PCP) dated 12/21/21: a short range goal included "I would like to get on suboxone ...if not I will go and find some more fentanyl to use ..."

Review on 2/2/22 of a local newspaper article dated 12/27/21 revealed:
-DC #8 was walking on a local highway on Christmas Eve night.
-DC #8 died from blunt force trauma after being struck by a motorist.

Review on 1/25/22 of the North Carolina (NC) Incident Response Improvement System (IRIS) report for DC #8 dated 12/29/21 revealed:
-Has this incident resulted in or is it likely to result in ...a report in a newspaper ...? No
-Does consumer have TBI (Traumatic Brain Injury)? No.
-When did the consumer last receive a mental health service? 12/23/21.
-Did the consumer express any suicidal ideation during the last mental health service? No.
-Did the consumer receive substance abuse services? No.
-When did the consumer last receive a substance abuse service? 12/23/21.
-Did the consumer express any suicidal ideation during the last substance abuse services? No.

Review on 2/4/22 of the NC Incident Response Improvement System revealed:
-There was no updated report in the system to correct the discrepancies intially reported.

Review on 1/25/22 of a Death Review dated 1/4/22 completed by the facility for DC #8

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V 367	Continued From page 20 revealed: -1.) Strengths: " ...The consumer was clear on his desire to be placed on Suboxone so he could stay away from Fentanyl ..." -2.) What does the chart review reveal about the level/quality of clinical care? " ...Consumer requested to leave before treatment was completed ...Consumer admitted to using fentanyl but requested to leave so he would not lose his job which he had just started." -3.) Was there an adequate assessment of lethality in this case and were appropriate measures taken to insure the client's safety? "There was an adequate assessment of lethality which showed no evidence of danger to self or others." -5.) Is there evidence that "best practices" were or were not adhered to? "In this case, 'best practice' standards were adhered to." -6.) Is there evidence that proper documentation practices were used? "All clinical information was available and documentation showed consumer's desire and competence to leave inpatient treatment." -7.) Recommendations: (What are the recommendations that can taken from this case and applied to future situations?) "Without justification to support the need for involuntary commitment on the basis of danger to self or danger to others, consumer maintains his right to make choices regarding treatment." Interview on 1/25/22 and 1/26/22 with the Physician revealed: -Facility staff had not informed her about the incident involving DC #8. -She did not usually review facility incident reports. -She stated, "[Facility Director] now realizes he made a mistake by not letting me know."	V 367		

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V 367	Continued From page 21 Interview on 1/26/22 with the Facility Director revealed: -He received a phone call from someone that informed him DC #8 had been hit by a vehicle. -After the phone call, he saw a newspaper article about the incident involving DC #8. -He completed the first 3 pages of the incident report. -He also completed a death report which had a few questions about what the facility could have done better. -He could not remember what he wrote on the death review but he indicated that he tried to encourage DC #8 to stay at the facility but he refused. -DC #8 expressed suicidal ideation at admission to the facility. -It was possible that he referred to an "older chart" when he filled out the incident report. This deficiency is cross referenced into 10A NCAC 27D.0304 Protection from Harm, Abuse, Neglect or Exploitation (V512) for a Type A1 rule violation and must be corrected within 23 days.	V 367		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy.	V 512		

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V 512	Continued From page 22 (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by: Based on record reviews, observation and interviews, 2 of 6 audited staff members (Registered Nurse (RN) #1, and the Facility Director) neglected 1 of 1 Deceased Client (DC #8). The findings are: CROSS REFERENCE: 10A NCAC 27G.0604 Incident Reporting Requirements for Category A and B Providers (V367). Based on record reviews and interviews, the facility failed to submit an updated report to all required report recipients by the end of the next business day whenever information provided in the report may be erroneous, misleading, or otherwise unreliable. Review on 2/25/22 of North Carolina (N.C) General Statute 122C-252 revealed: -"...24-hour facilities licensed under this Chapter...may be designated by the Secretary as facilities for the custody and treatment of involuntary clients. Designation of these facilities shall be made in accordance with rules of the Secretary that assure the protection of the	V 512		

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V 512	Continued From page 23	V 512		

client...Facilities so designated may detain a client..."

Review on 2/25/22 of N.C. General Statute 122C-255 revealed:
-"Each 24-hour facility that (i) falls under the category of nonhospital medical detoxification, facility based crisis service...is designated by the Secretary of Health and Human Services as a facility for the custody and treatment of individuals under a petition of involuntary commitment..."

Review on 1/25/22 of DC #8's Affidavit and Petition for Involuntary Commitment (IVC) revealed:
-The Petitioner was DC #8's mother.
-The Petition was signed by a Magistrate on 12/20/21.
-"Respondent is suicidal. He talks about hurting himself and others. He talks about guns but does not have one. He states he is going to burn his Mother's place down. He's up all night, crying and running around. He is talking to himself. He smacks himself in the face stating 'You M*****F****r.' He pulls all his clothes off. He cries stating 'Why Me' and holds his head stating that they hate him and don't want him. He will stand in one spot for awhile and not move. He is moving things and pulling things out of cabinets. He was in the floor mopping with his hands but there was no water or anything there. Petitioner states he takes little blue pills and says it's for headaches. He stated he was going to blow his whole check and get high."

Review on 1/25/22 of DC #8's Findings and Custody Order for IVC revealed:
-The Order was signed by a Magistrate on 12/20/22 at 9:23 am.
-DC #8 was taken into custody by a local law

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V 512	Continued From page 24	V 512		

enforcement officer on 12/20/21 at 9:52 am.
-DC #8 was delivered to and placed "in the custody" of Cleveland Crisis and Recovery Center (CCRC) on 12/20/21 at 9:53 am.

Review on 1/25/22 of DC #8's First Examination for IVC revealed:
-The first evaluation was conducted on DC #8 on 12/20/21 at 12:00 pm and signed by the Facility Director.
-DC #8's mother had recorded his behavior on her phone and reported that DC #8 "was having conversations with the walls, talking to himself, slapping himself in the face, cursing at himself ...wrecked three cars in a year's time ..."
-DC # 8 reports he " ...has been snorting Fentanyl 2-3 pills a day with last use this morning ... reports smoking approximately 7 grams of marijuana every day, snorting cocaine 1-2 times a month and taking benzodiazepines ...reports suicidal ideations (SI) ...acknowledges both auditory and visual hallucinations ...is oriented in all spheres ...attention and concentration are good ...speech is within normal limits ...reports feeling depressed ...affect is neutral. Thought processes are coherent. At this time, the respondent (DC #8) is a danger to himself due to his substance use and the commitment is upheld ..."
-"It is my opinion that the respondent (DC #8) meets the criteria for the selected type of commitment" Substance Abuse "as the respondent is ...A Substance Abuser; Dangerous to: Self ..."

Review on 1/25/22 of DC #8's Second Examination for IVC revealed:
-The second evaluation was conducted on DC #8 on 12/21/21 at 10:00 am and signed by the physician.

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V 512	Continued From page 25 -DC #8 " ...denies he threatened to burn down mother's apartment ...denies any psychotic symptoms now and denies any homicidal (HI) or suicidal thoughts ...is alert and oriented ...speech is normal volume and rate. Language is normal ...Affect is mood congruent ...Insight and judgment are limited. He is denying some of the things that have happened and minimizes his behavior ..." -"It is my opinion that the respondent (DC #8) meets the criteria for the selected type of commitment" Inpatient "as the respondent is ...An individual with a mental illness; Dangerous to: Self ..." -An Inpatient Commitment for 5 days was recommended. Review on 2/2/22 of DC #8's Notice of Commitment Change dated 12/23/21 and filed with the Clerk of Superior Court (CSC) on 12/28/21 revealed: -"Note: If current status is Inpatient Commitment, signature must be that of Attending Physician." -The form was not signed by a Physician. -The only signature on the form was that of the Facility Director. Review on 1/25/22 of DC #8's Crisis Assessment dated 12/20/21 revealed: -During the assessment DC #8 "was laughing inappropriately and acted like he was responding to internal stimuli." -DC #8 "reports that he has been seeing shadow people out of the corner of his eyes almost every other day and has been hearing voices call his name ..." -DC #8 reported that he attempted to commit suicide 7-8 times. -The last suicide attempt was in 2019 when DC #8 tried to drive into a tree.	V 512		

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CLEVELAND CRISIS AND RECOVERY CENTEF	609 NORTH WASHINGTON STREET SHELBY, NC 28150

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V 512	Continued From page 26 -"Consumer is in need of a successful discharge plan due to consumer running a high risk of relapse." Review on 1/25/22 of DC #8's Weekly Team Meeting Note dated 12/21/21 revealed: -One statement indicated DC #8 was a "self-referral ...seeking assistance with substance use disorder ..." -Another statement indicated that DC #8 "was brought in under IVC petition due to consumer having SI and hallucinations." -"It is recommended that client complete treatment to address substance use disorder and develop a aftercare/discharge plan focused on successful recovery from active addiction and mental health." Review on 1/25/22 of DC #8's Progress Note dated 12/23/21 revealed: -The note was signed by RN #1. -" ...Consumer very adamant about discharge today. Consumer reported feeling great, and he could stop using drugs whenever he wanted. Explained to [Facility Director] he would pay for a hotel and go back to work ...Consumer was coherent with no SI/HI nor s/s (signs/symptoms) of psychosis. [Facility Director] and this nurse staffed the case with [the physician] who ordered release today ...Consumer left via on foot with valuable. He was recommended to follow up with outpatient and a Suboxone Clinic." -D/C #8 "discharged from FBC (Facility Based Crisis) AMA (Against Medical Advice) at 215 pm on 12/23/21 ..." Review on 1/25/22 of DC #8's Discharge Orders revealed: -An order dated 12/23/21 at 1:15 pm to discharge consumer which was signed by RN #1.	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-171	A. BUILDING: _____ B. WING _____	R 02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND CRISIS AND RECOVERY CENTEF	609 NORTH WASHINGTON STREET SHELBY, NC 28150

(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 512	Continued From page 27 Review on 1/25/22 of DC #8's Service Note dated revealed: -Labeled as a Late Note. -Note was dated 12/21/21 but electronically signed by the Physician on 12/23/21 at 04:57:26 pm. -DC #8 " ...denies any psychotic symptoms ...denies any homicidal or suicidal thoughts ...denies things that were documented on the involuntary commitment papers, but does admit to using drugs ...Presently, we will continue the IVC for him to get treatment for his opioid use disorder." Review on 1/25/22 of DC #8's Person-Centered Profile (PCP) dated 12/21/21 revealed: -Short range goals which included "I would like to get on suboxone so that I can stay away from it, if not I will go find some more fentanyl to use. The fentanyl stops my body from aching, because I flip my jeep three times and was hit by ambulance walking ..." -Date Goal was Reviewed: 12/23/21. -"Consumer is discharged, leaving AMA ..." Review on 1/25/22 of DC #8's Discharge Note dated 12/23/21 revealed: -"Consumer presents to Cleveland Crisis and Recovery Center/BHU (Behavioral Health Unit) as a self-referral ...seeking assistance with substance use disorder ..." -Reason for Discharge: "Against Medical Advice." -Goals Achieved/Progress Made: "[DC #8] is leaving the facility against medical advice." Interview on 1/24/22 with the Clinical Manager revealed: -There was an error on the Weekly Team Meeting Note that indicated DC #8 was a "self-referral."	V 512		

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	MHL023-171	A. BUILDING: _____ B. WING _____	R 02/25/2022

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CLEVELAND CRISIS AND RECOVERY CENTEF	609 NORTH WASHINGTON STREET SHELBY, NC 28150

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V 512	Continued From page 28	V 512		

-She was responsible for the error on the note.
-DC #8 was an IVC.
-She stated, "....If a client is IVC and wants to leave, the doctor is the only one that can drop the IVC order. We can't. The nurse is responsible for calling the doctor and then the consumer has to sign a document to show that they went from IVC to voluntary."

Interview on 1/24/22 with Clinician #5 revealed:
-" ...I worked the day [DC #8] left. I remember doing his discharge. From my understanding, he was discharged because his IVC was dropped...I did his discharge because [RN #1] told me his IVC was dropped and he (DC #8) was requesting to leave AMA. When I did my last mental status, he denied SI/HI and everything and I made a follow up outpatient appointment because that was the only thing he would agree to. He wanted to get back to work. There should be documentation in the doctor note or the nurse's note. It's not always entered right away. The only part I played was making sure he had a safe discharge plan. I'm pretty sure he left on foot. He walked. Usually the most times, the nurse puts it in their note. I remember his mom IVC'd him so she would not have picked him up because she wanted him to have treatment. [DC #8] had a job in the [local business] warehouse and he kept saying he wanted to get back to work. He didn't live far from here."

Interview on 1/19/22 with RN #1 revealed:
-DC #8 "had substance induced psychosis from what I remember. He stayed a few days and then he was coherent. He wanted to leave to go to an outpatient suboxone clinic. [Facility Director] and I processed (staffed it) with [Physician] and the doctor said to allow him to leave. I was only present for the day of discharge. The day we let

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	MHL023-171	A. BUILDING: _____ B. WING _____	R 02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND CRISIS AND RECOVERY CENTEF	609 NORTH WASHINGTON STREET SHELBY, NC 28150

(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 512	Continued From page 29	V 512		

him go. I can't remember if someone came and picked him up, or if he left by walking on foot. Off-hand I can't recall. I just remember getting the order that day to let him go and then it's actually peer support staff that assist with getting the consumer out the door."

Interview on 1/15/22 with RN #1 revealed:
-Both he and the Facility Director told the Physician that DC #8 was coherent and no longer displaying symptoms of psychosis.
-He was aware DC #8 was an IVC when he called the Physician.
-The substance induced psychosis was the main reason DC #8 had been placed under IVC.
-He could not recall if the information about the IVC was communicated to the Physician.
-He stated, "I know IVC has been overturned before by a phone call to [Physician], at least once before but I can't give you a time date or number of occurrences."

Interview on 1/26/22 with the Facility Director revealed:
-He upheld DC #8's IVC.
-He indicated on the IVC that DC #8 was mainly a substance abuse commitment.
-The Physician indicated DC #8 was an inpatient commitment because she diagnosed him with a Mood Disorder as well as his underlying substance abuse.
-DC #8 wanted to start suboxone, but he needed a means to pay for suboxone.
-DC #8 did not know whether or not he had insurance through his employer.
-On 12/23/21 DC #8 "was talking to everybody and saw other people getting discharged and so he requested to be discharged because he didn't want to lose his job ...I was present that day. [RN #1] and I consulted with [DC #8]. He denied SI/HI

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	MHL023-171	A. BUILDING: _____ B. WING _____	R 02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND CRISIS AND RECOVERY CENTEF	609 NORTH WASHINGTON STREET SHELBY, NC 28150

(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 512	Continued From page 30	V 512		

and wanted to be discharged. There were no issues. He was ...adamant about discharge ...I asked if he was going back to his ex-girlfriend's or his Mom's house and he said he was not going back to either place and that he was going to get a motel room ...[RN #1] and I staffed the case with [Physician] who ordered the discharge, so he (DC #8) left on foot ...I encouraged him at discharge to follow up with counseling because of how dangerous fentanyl was ...What I didn't like about this is [RN #1] put that he (DC #8) was discharged AMA ...We have issues with how staff describe AMA. [Physician] did not use the term AMA. Our staff seem to think if a consumer doesn't complete the program, then it is AMA. They don't understand ..."
-He did not believe that clients should have to be re-evaluated by a doctor to have an IVC overturned.
-It was common practice for clients to be discharged without seeing the doctor.
-" ...[RN #1] and I both talked to [Physician] at the same time and based on what we were seeing and what we told ...she (the Physician) felt like he (DC #8) could be discharged ...Staff here, or at least [RN #1] and I have been doing this for years, so it was based on what we were seeing and the one thing he (DC #8) had going for him was his job ...[DC #8's] SI, I think was more of a level of frustration instead of just wanting to die. He (DC #8) was frustrated with his Mom, but he had a job and he did not want to lose that job and the rest of the time he was here he didn't verbalize SI/HI ..."
-He was unaware that DC #8's record indicated that there was a history of suicide attempts.
-He had tried to encourage DC #8 to stay at the facility.
-He stated, "I asked him (DC #8) if I could call his ex-girlfriend, or his Mom and he absolutely

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	MHL023-171	A. BUILDING: _____ B. WING _____	R 02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND CRISIS AND RECOVERY CENTEF	609 NORTH WASHINGTON STREET SHELBY, NC 28150

(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 512	Continued From page 31	V 512		

refused and said he didn't want them to know his business. We had a release of information for us to speak with his ex-girlfriend but he (DC #8) said if our phone call to her would prevent him from leaving then he did not want us to call her ...I do hate the accident happened. It weighs heavily on our minds ..."

Interview on 1/25/22 and 1/26/22 with the Physician revealed:
-A consumer must be voluntary to leave against medical advice.
-She did not give an order for an AMA discharge.
-RN #1 made an error in saying DC #8 was discharged AMA.
-She could not remember if RN #1 communicated when obtaining the discharge order that DC #8 was IVC.
-It was possible that there could have been miscommunication about DC #8's IVC status.
-DC #8's Mother reported serious issues in the Petition.
-DC #8 had denied a lot of what was in the IVC Petition.
-" ...so, we hold for evaluation to see if we are finding any of those symptoms. I recommended 5 days of IVC to evaluate and observe for the behavior ...Any IVC being discharged ideally, would be for us (Physician, or Physician Assistants) to see the patient before being released ...[Facility Director] saw the patient along with [RN #1] and they called me. It was a Thursday. I wasn't making rounds that day, but there was a note from [Lead Nurse] that the consumer was not displaying psychosis, or agitation and was participating in groups ...I'm reading that there was nobody here to pick him (DC #8) up, or anything so it's possible he used drugs again and exhibited poor judgment and got hit by a car ..."

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	MHL023-171	A. BUILDING: _____ B. WING _____	R 02/25/2022

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CLEVELAND CRISIS AND RECOVERY CENTEF	609 NORTH WASHINGTON STREET SHELBY, NC 28150

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V 512	Continued From page 32 -It was not the normal practice for overturning an IVC. -DC #8 should have been re-evaluated by the Physician, or a mid-level provider. Interview on 1/21/22 with a State Trooper with the South Carolina Highway Patrol revealed: -He was the investigator for a motor vehicle accident involving DC #8. -The accident occurred at night on 12/24/21. -DC #8 was walking on a roadway while wearing dark clothing. -DC #8 was struck and killed by a vehicle. -The death had not been labeled as a suicide. -A toxicology report was not yet available. Efforts were made on 1/25/22 and 1/28/22 to interview the (ex) girlfriend of DC #6. Phone calls were not returned. Interview on 1/25/22 with DC #8's Mother revealed: -"I had gone to the Magistrate office and filled out the necessary paperwork to get my son some help. By the time I got home the cops were here at my home and they handcuffed him and put him in the car. This was the last time I saw my son alive. I was told my son was at the recovery center. I knew he needed help. He was in very bad shape. He told the cops the first chance he got he would hurt himself ...Nobody from the recovery center called me to inform me that [DC #8] had left the center. I was supposed to be contacted when he left. I could have spoke to my son and convinced him to stay. He would maybe still be alive today. I believe he would have listened to me. He would have listened and I know he would still be alive today. Nobody from the recovery center still has ever reached out to me from there. Nobody has said sorry. I am the	V 512		

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	MHL023-171	A. BUILDING: _____ B. WING _____	R 02/25/2022

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CLEVELAND CRISIS AND RECOVERY CENTEF	609 NORTH WASHINGTON STREET SHELBY, NC 28150

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V 512	Continued From page 33	V 512		

one that had him put there. They could have called me and said your son wants to leave and gave me a chance to speak to him but I didn't get that chance. I will never see my son again ...I don't live far from the recovery center so I am thinking my son walked ...I don't think anyone picked him up from the center ...I spoke with his girlfriend and she was not with my son ...My son didn't matter to them. They let him out in less than 3 days. If I had known they would do that then I would have kept him home and helped him here. 3 days after telling me and the cops that he was going to hurt himself. They said my son was suicidal and I knew he was suicidal. How did they let him out of there in 3 days and not contact his mom? My family is broken hearted and I don't know if I will ever be right again. He got 3 kids. 3 kids that are the age of 13, 14 and 8 and I had to bury my son and their father. I don't know what to tell these kids that they don't have a father and I would never wish this on any parent. Please if I can help a family to please just tell the center to call the family when there are things like this. I don't want anyone to ever go through this again. It was hard to put my son in this place. It took a lot out of me to do him like that and now I feel like he is dead because of my decision to get him help. I just wish they would have contacted me and given me a chance to have my son stay in there. He was in there once before and they called me and they asked me if I thought he was ready to get out and if he had a place. They didn't even know where he went or where he was going. They just let him out and let him go and now my son died and got killed on a highway 2 1/2 hours away from home and I couldn't even get to him. I just felt like I failed him. My son has been passed away a month ago and they still haven't reached out. Christmas will never be the same again ..."

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CLEVELAND CRISIS AND RECOVERY CENTEF	609 NORTH WASHINGTON STREET SHELBY, NC 28150

(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 512	Continued From page 34 Review on 1/28/22 of a Plan of Protection completed and signed by the Facility Director revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? Prior to discharge, any consumer, whether Voluntary or Involuntary will be seen by a medical provider. Describe your plans to make sure the above happens. The Nurse on Duty will utilize the 'PHYSICIAN TO BE SEEN SHEET' for any consumer wanting to see the medical provider for discharge." Review on 1/31/22 of a 2nd Plan of Protection completed and signed by the Facility Director on 1/29/22 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? Prior to discharge, any consumer, whether Voluntary or Involuntary will be seen by a medical provider. Describe your plans to make sure the above happens. The Nurse on Duty will utilize the "PHYSICIAN TO BE SEEN SHEET" for any consumer wanting to see the medical provider for discharge. The Nurse on Duty will document the the approved discharge on the Physician's Order Sheet and Shift Note. The Medical Records staff will ensure documentation is present and correct. The Facility Director will review discharge." Review of a 3rd Plan of Protection completed and signed by the Facility Director revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? Prior to discharge consumer's that have been held under Involuntary Commitment will be seen	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-171	A. BUILDING: _____ B. WING _____	R 02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND CRISIS AND RECOVERY CENTEF	609 NORTH WASHINGTON STREET SHELBY, NC 28150

(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 512	Continued From page 35	V 512		

by the medical provider.
All Incident and Death Reports will be completed in it's entirety to ensure sufficient information is provided while errors are corrected.
Describe your plans to make sure the above happens.
The Nurse on Duty will utilize the "PHYSICIAN TO BE SEEN SHEET" to the list any consumer requesting discharge and needs to see the medical provider. If the medical provider approves the discharge of a consumer under involuntary commitment, the nurse will document the approved discharge on the Physician Order Sheet and document in the shift note. Medical Records will ensure the documentation is present and correct. The Facility Director will ensure a Change of Commitment is forwarded to the Clerk of Court.
All staff will be trained on the completion of the Incident and Death Report form no later than March 1, 2022 to ensure the form is completed correctly and required information is present with no errors. The Facility Director in conjunction with the Utilization Management Department at Phoenix Counseling Center."

This facility is licensed to serve clients with mental health and substance abuse disorders including but not limited to Opioid Dependence with Opioid Induced Psychotic Disorder with Hallucinations; Cannabis Dependence; Cocaine Abuse and Sedative Hypnotic, Anxiolytic Abuse. Deceased Client (DC) #8 was brought to the facility on 12/20/21 after being petitioned for Involuntary Commitment (IVC) by his Mother. DC #8 had been displaying psychotic behavior and expressing suicidal ideation. On 12/20/21, the Facility Director conducted a first exam on DC #8 and upheld the IVC. On 12/21/21, the Physician

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	MHL023-171	A. BUILDING: _____ B. WING _____	R 02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND CRISIS AND RECOVERY CENTEF	609 NORTH WASHINGTON STREET SHELBY, NC 28150

(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 512	Continued From page 36 conducted a second exam on DC #8 and upheld the IVC with a recommendation of inpatient treatment for 5 days. On 12/23/21, DC #8 was insistent about being discharged. The Facility Director and RN #1 contacted the Physician by phone to request a discharge order. The decision to discharge DC #8 was based solely on verbal reports from RN #1 and the Facility Director. It could not be determined if DC #8's IVC status had been communicated when RN #1 and the Facility Director spoke with the Physician. The protocol for having an involuntary commitment change was not followed. Furthermore, RN #1 documented that DC #8 was discharged against medical advice. DC #8's Mother was not notified that he was being discharged. The Facility Director was aware that staff had permission to contact the ex-girlfriend of DC #8, but no attempts were made to contact her. DC #8 left the facility alone on foot. On 12/24/21, DC #8 was struck and killed by a motorist while walking on a highway in South Carolina. The Facility Director submitted an incident report into the NC Incident Response Improvement System (IRIS) which contained numerous discrepancies. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $10,000.00 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 512		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-171	A. BUILDING: _____ B. WING _____	R 02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND CRISIS AND RECOVERY CENTEF	609 NORTH WASHINGTON STREET SHELBY, NC 28150

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V 537	Continued From page 37 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 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	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-171	A. BUILDING: _____ B. WING _____	R 02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND CRISIS AND RECOVERY CENTEF	609 NORTH WASHINGTON STREET SHELBY, NC 28150

(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 537	Continued From page 38	V 537		

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.
(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

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	MHL023-171	A. BUILDING: _____ B. WING _____	R 02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND CRISIS AND RECOVERY CENTEF	609 NORTH WASHINGTON STREET SHELBY, NC 28150

(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 537	Continued From page 39	V 537		

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;
(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

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V 537	Continued From page 40 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. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 6 of 6 audited staff (Clinical Manager, Registered Nurse (RN) #1, Clinician #2, Staff #6, Staff #7 and Staff #8) had training in the use of seclusion, physical restraint and isolation time out at least annually. The findings are: Review on 1/13/22 of the Clinical Manager's record revealed: -Date of Hire: 7/14/14. -No current training in the use of seclusion, physical restraint and isolation time out. Review on 1/13/22 of RN #1's record revealed:	V 537		

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V 537	Continued From page 41 -Date of Hire: 9/6/16. -No current training in the use of seclusion, physical restraint and isolation time out. Review on 1/13/22 of Clinician #2'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 1/13/22 of Staff #6's record revealed: -Date of Hire: 12/7/20. -No current training in the use of seclusion, physical restraint and isolation time out. Review on 1/13/22 of Staff #7'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 1/13/22 of Staff #8's record revealed: -Date of Hire: 3/14/13. -No current training in the use of seclusion, physical restraint and isolation time out. Interview on 1/12/22 with Clinician #2 revealed: -" ...I don't think we do the plus (Evidence Based Protective Interventions (EBPI)) training because we don't do the hands on. If there's immediate risk of harm to the client we have been trained in the physical interventions but they are only used as a last resort. 95% of the time there is a police officer on site to help ..." Interview on 1/12/22 with Staff #7 revealed: -" ...EBPI we usually get parts A and B. I don't really remember the last time we had that if we did restraints. I don't know. I just don't remember what parts we did the last time. I don't think we did the part B of the holds ..."	V 537		

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V 537	Continued From page 42 Interview on 1/19/22 with the Facility Director revealed: -After the last survey, staff were re-trained in EBPI. -He stated, " ...The question is, what training did they get. You'll have to check with [Clinician #4], she's the internal EBPI instructor for Phoenix Counseling (Licensee) ..." Interview on 1/28/22 with Clinician #4 revealed: -She worked for Phoenix Counseling Center (PCC) as a Clinician and an EBPI instructor. -The 3 levels of EBPI training were Preventative, Base and Base Plus. -EBPI Preventative training only utilized verbal de-escalation techniques. -The verbal de-escalation techniques were included with all levels of EBPI training. -EBPI Base training was basic physical blocking techniques. -EBPI Base Plus training would be any type of restrictive intervention. -Each facility could pick and choose which techniques they wanted staff to be trained in. -PCC chose to train staff in just the base level of EBPI. This deficiency is cross referenced into 10A NCAC 27G.5001 Scope (V269) for a Failure to Correct Type A1 rule violation.	V 537		