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	MHL0601361	A. BUILDING: _____ B. WING _____	06/07/2023

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SECU YOUTH CRISIS CENTER, A MONARCH P	1810 BACK CREEK DRIVE CHARLOTTE, NC 28213

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V 000	INITIAL COMMENTS A complaint survey was completed on 06/07/2023. One complaint was unsubstantiated (intake #NC00198766) and the other compliant (intake #NC00200193) was substantiated. 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 and 10A NCAC 27G .5000 Facility Based Crisis Service for Individuals of All Disability Groups. This facility is licensed for 16 and currently has a census of 10. The survey sample consisted of audits of 4 former clients.	V 000	This page intentionally left blank	
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid	V 108	DHSR - Mental Health JUL 05 2023 Lic. & Cert. Section	

Dr. Wyle Hess, PhD, LCMHC
6/30/2023

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V 108	Continued From page 1 including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 3 of 3 audited Staff (#1, #2, and #3) and 2 of 2 Former Staff (FS #4 and #5) had the required training to meet the MH/DD/SA needs of clients. The findings are: Review on 05/15/2023 of Staff #1's record revealed: -Hire date 01/31/2022. -Job title Behavior Technician. -No MH/DD/SA training. Review on 05/22/2023 of Staff #2's record revealed: -Hire date 8/29/2022. -Job title Behavior Technician. -No MH/DD/SA training. Review on 05/22/2023 of Staff #3's record revealed: -Hire date 11/18/2019. -Job title Behavior Technician.	V 108	A training profile is created for each position that encompasses the requirement of MH/DD/SA needs. Director will be trained by the VP of Operations in what these trainings entail, where to locate these, and will be able to provide these for audits.	8/29/2023

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V 108	Continued From page 2 -No MH/DD/SA training. Review on 05/26/2023 of FS #4's record revealed: -Hire date 01/30/2023. -Termination date 04/10/2023. -Job title Behavior Technician. -No MH/DD/SA training. Review on 05/26/2023 of FS #5's record revealed: -Hire date 06/21/2022. -Termination date 04/27/2023. -Job title Behavior Technician. -No MH/DD/SA training. Interview on 05/24/2023 with Staff #1 revealed: -Was up to date on required trainings. Interview on 05/24/2023 with Staff #2 revealed: -Had required trainings. Interview on 05/24/2023 with Staff #3 revealed: -Was up to date on required trainings. Attempted interview on 06/01/2023 with FS #4 was unsuccessful due to the incorrect contact number provided by the facility. Attempted interviews on 06/01/2023 and 06/06/2023 with FS #5 were unsuccessful due to no response to phone calls. Interview on 05/15/2023 with the Director of Operations revealed: -Did not know the name of the required MH/DD/SA training used by the facility. -Requested the training information from the Vice President of Operations on 05/15/2023.	V 108	This page intentionally left blank	

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V 108	Continued From page 3 Interview on 05/15/2023 with the Vice President of Operations revealed: -"I will have to get back with you with that information (name of the MH/DD/SA training used by the facility)." Required MH/DD/SA training information was never received prior to survey exit date 06/07/2023.	V 108		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) 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. (f) The governing body for each facility shall develop and implement policies and procedures	V 110	This page intentionally left blank	

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V 110	Continued From page 4 for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 2 Former Staff (FS #4) demonstrated competency in knowledge, skills, and abilities required by the population served. The findings are: Review on 05/26/2023 of Former Client (FC) #3's record revealed: -Admitted 03/11/2023. -Discharged 03/30/2023. -Diagnosed with Major Depressive Disorder, Generalized Anxiety Disorder, Unspecified Trauma and Stressor Related Disorder, Conduct Disorder, and Cannabis Abuse. -Age 17. Review on 05/26/2023 of FC #4's record revealed: -Admitted 03/16/2023. -Discharged 03/31/2023. -Diagnosed with Unspecified Depressive Disorder, Generalized Anxiety Disorder, and Cannabis Abuse. -Age 17. Review on 05/26/2023 of FS #4's personnel record revealed: -Hire date 01/30/2023. -Termination date 04/10/2023. -Job title Behavior Technician.	V 110	Program Manager and/or Director of Operations will complete BT Competency in knowledge, skills, and abilities by the population served with all new staff within their first 2 weeks of Orientation. All staff review the Employee Handbook, which discusses relationships with patients. This review is completed at Orientation and as changes occur. Additionally Boundaries have been discussed in weekly All-Staff Meetings by the Program Manager and Director Of Operations. This includes, but is not limited to, professional relationships with patients and social media guidelines.	8/29/2023 & Ongoing

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V 110	Continued From page 5 -Client Rights-Abuse, Neglect & Exploitation Attestation 2/10/2023. -Code of Conduct & Ethics Attestation 02/10/2023. Review on 05/19/2023 of a Facility Incident Report dated 04/10/2023 for FC #3 revealed: -"Completed by [Director of Operations]. -Brief Description of Incident: The Director (Director of Operations) received a call from a former client [FC #3] parent/guardian stating that staff [FS #4] has been calling and texting her son, since his discharge from the facility. She stated that she has text messages of the inappropriate contact. -Systemic/Preventative Measures: The guardian spoke with the Director (Director of Operations) on Monday 04/10/2023 informing the Director that she believed that staff was texting her son since his discharge and wanted to make the Director aware. Director contacted her supervisor [Vice President (VP) of Operations] and made her aware of the allegations. Director also met with Staff [FS #4] in question. Staff denied the allegations and ultimately resigned the same day, saying it was because of the allegations." Review on 05/19/2023 of a Facility Incident Report dated 04/11/2023 for FC #4 revealed: -"Completed by [Director of Operations]. -Brief Description of Incident: The guardian of another youth (FC #3's Guardian) stated that she saw text messages that [FS #5] has been texting [FC #4] and possibly messaging him on [social media]. She (FC #3's Guardian) also alleges [FS #5] would take [FC #4] off the floor for hours at a time. -Immediate Response/Action to Address Event: Facility Based Crisis (FBC) Director (Director of Operations) contacted youth's mother (FC #4's	V 110	This page intentionally left blank	

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V 110	Continued From page 6 Guardian) to make her aware of the possibility of staff texting her son. After investigating, it was determined that [FS #5] had not been texting [FC #4] but another former staff [FS #4] has been texting [FC #4] since his discharge." Interview on 06/01/2023 with FC #3 revealed: -"[FC #4] gave me her (FS #4) number. Me and staff [FS #4] were texting each other." -"We (FC #3 and FS #4) would text about what we were doing throughout the day." -"I do not talk to her anymore." -FC #3's Guardian monitored and blocked his social media accounts to ensure he no longer had contact with FS #4. Interview on 05/26/2023 with FC #3's Guardian revealed: -" ...She (FS #4) had pictures of my son (FC #3) walking around the center (facility) in his underwear. I have pictures of text messages and [social media] postings from her." -"She (FS #4) texted my son when we were at the beach, and I really was about to tell her about herself. I reported it to [Licensee], and they said they would investigate it. I sent them everything (screenshots of text messages, social media postings, and pictures of FC #3 at the facility in his underwear) ." -"There were no pictures of them (FS #4 and FC #3) at the center together. But when you read these text messages, you can get from it whatever you want." -"She (FS #4) was not the only person at [Licensee] known for dealing with these boys. Another boy named [FC #4] was involved too." -"Him (FC #3) and her (FS #4) were in rooms alone for long periods of time. He (FC #3) will not tell me if they had (sexual) relations."	V 110	To clarify, the picture of the youth: he was wearing a pair of sweatpants, with his underwear over his sweatpants.	

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V 110	Continued From page 7 Attempted interviews on 06/01/2023 and 06/06/2023 with FC #4's Guardian were unsuccessful due to no response to phone calls. Attempted interview on 06/01/2023 with FS #4 was unsuccessful due to the incorrect contact number provided by the facility. Interview on 06/07/2023 with the Director of Operations revealed: -Investigated the allegations against FS #4, but no additional details were provided. Interview on 06/07/2023 with the VP of Operations revealed: -Allegations against FS #4 were investigated by the Director of Operations, but no additional details were provided. Interview on 06/07/2023 with the VP of Regulatory Affairs revealed: -"We determined there were some interactions (between FS #4 and FC #3) on social media."	V 110	This page intentionally left blank	
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.	V 132		

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V 132	Continued From page 8 b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to ensure that the Health Care Personnel Registry (HCPR) was notified of all allegations against health care personnel. The findings are:	V 132	HCPR was not contacted as an allegation was not filed. The investigation result showed there was no action that warranted an allegation of abuse, neglect, or exploitation. [redacted] was the Investigation packet SECU competed for the Incident that occurred on 4/10 & 4/11/2023. This was sent to the surveyor on 5/15/2023.	

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V 132	Continued From page 9 Review between 05/12/2023 and 06/06/2023 of the facility records revealed: -No documentation of HCPR notifications for the allegation of suspected abuse incidents dated 04/10/2023 for FC #3 against FS #4 and 04/11/2023 for FC #4 against FS #5. Review on 05/19/2023 of a Facility Incident Report dated 04/10/2023 for FC #3 revealed: -"...Director (Director of Operations) also met with Staff [FS #4] in question. Staff denied the allegations and ultimately resigned the same day, saying it was because of the allegations." Review on 05/19/2023 of a Facility Incident Report dated 04/11/2023 for FC #4 revealed: -"She (FC #3's Guardian) also alleges [FS #5] would take [FC #4] off the floor for hours at a time." Interview on 05/26/2023 with FC #3's Guardian revealed: -Reported to the Director of Operations suspected abuse for FC #3 against FS #4 and FC #4 against FS #5. Attempted interviews on 06/01/2023 and 06/06/2023 with FC #4's Guardian were unsuccessful due to no response to phone calls. Attempted interview on 06/01/2023 with FS #4 was unsuccessful due to the incorrect contact number provided by the facility. Attempted interviews on 06/01/2023 and 06/06/2023 with FS #5 were unsuccessful due to no response to phone calls. Interview on 06/07/2023 with the Director of	V 132	Investigation packet was sent to surveyor on 5/15/2023 @ 10:21am. Please see attached email dated 5/15/2023 @ 10:21am. This link included the following IRIS reports: [redacted] This also included 3 months of Investigations: [redacted] [redacted] was the Investigation packet SECU competed for the Incident that occurred on 4/10 & 4/11/2023.	

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V 132	Continued From page 10 Operations revealed: -Investigated the allegations against FS #4 and FS #5, but no additional details were provided. -Did not notify HCPR of allegations against FS #4 and FS #5. Interview on 06/07/2023 with the Vice President (VP) of Operations revealed: -Did not ensure HCPR was notified of allegations against FS #4 and FS #5. Interview on 06/07/2023 with the VP of Regulatory Affairs revealed: -"We looked into the incidents (allegations for FS #4 dated 04/10/2023 and FS #5 dated 04/11/2023) and determined they did not rise to the level of abuse, neglect, or exploitation."	V 132	Surveyor noted she could not open original link sent at 10: 21am. Director of Operations sent another email 5/15/2023 @ 3: 47pm that included the above IRIS reports individually attached. Director of Operations also sent another email 5/15/2023@ 2: 42pm that included all the above Investigation packets (108 total attachments). Please see attached emails sent on 5/15/2023 @ 2:42pm & 3: 47pm.	
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;	V 366		

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V 366	Continued From page 11 (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents;	V 366	This page intentionally left blank	

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V 366	Continued From page 12 (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law.	V 366	This page intentionally left blank	

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 _____	06/07/2023

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

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V 366	Continued From page 13 This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to implement written policies governing their response to level I, II, and III incidents. The findings are: Review on 05/19/2023 of the facility records revealed: -No Risk/Cause/Analysis for emergency call incidents to dispatch Emergency Medical Technicians (EMT's) dated 03/10/2023 and the Fire Department dated 04/21/2023. -No Risk/Cause/Analysis or documentation to support submission of the written preliminary findings of fact to the Local Management Entity/Managed Care Organization (LME/MCO) within five working days for the allegations of suspected abuse against Former Staff (FS) #4 dated 04/10/2023 and FS #5 dated 04/11/2023. Review on 05/19/2023 of Emailed Correspondence dated 05/19/2023 from the Director of Operations to the Division of Health Service Regulation (DHSR) Surveyor revealed: -Time: 11:28 am. -"I spoke with my supervisor (Vice President (VP) of Operations) and she made the executive team aware that we would be cited for not compliance/submission of the documents you requested. I informed them, again, that the spreadsheet will not suffice. You should be receiving the incident reports today." Interviews on 05/12/2023, 05/15/2023, 05/19/2023, and 06/07/2023 with the Director of Operations revealed: -Informed to provide the DHSR Surveyor an excel	V 366	3/10/2023: Error filed as non-emergency medical response. This was consumer behavior, the non-emergency transport was a Level II. Retraining will need to be completed to ensure staff are aware that this constitutes a Level II and an IRIS is to be completed. VP of Operations will retrain the Director of Operations and Nursing Manager on the definitions of incidents and what constitutes the need to file an IRIS. Notifications and appropriate timelines will also be retrained. This will be monitored ongoing by Director of Operations and VP of Operations. 4/21/2023: This was filed as an IRIS and was emailed to the state on 5/15/2023 (requested and emailed this day). Please see attached email from Director of Operations. [redacted] DSS was not contacted as an allegation was not filed. The investigation result showed there was no action that warranted an allegation of abuse, neglect, or exploitation. This investigation packet was emailed on 5/15/2023 to surveyor.	8/29/2023

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V 366	Continued From page 14 spreadsheet with facility incidents listed. -Informed by executive leadership on 05/15/2023 that it would take days to gather required level I, II, and III incident reports. -DHSR Surveyor would receive the required incident reports on 05/19/2023. -Did not complete and/or provide the Risk/Cause/Analysis for incidents dated 03/10/2023 and 04/21/2023. -Did not complete and/or provide the Risk/Cause/Analysis or submit the written preliminary findings of fact to the LME/MCO within five working days for the allegations against FS #4 dated 04/10/2023 or FS #5 dated 04/11/2023. Interviews on 05/15/2023 and 06/07/2023 with the VP of Operations revealed: -"They are pulling the information (incident reports)." -Did not ensure completion of and/or provide the Risk/Cause/Analysis for incidents dated 03/10/2023 and 04/21/2023. -Did not ensure completion of and/or provide the Risk/Cause/Analysis or ensure submission of the written preliminary findings of fact to the LME/MCO within five working days for the allegations against FS #4 dated 04/10/2023 or FS #5 dated 04/11/2023. Interview on 06/07/2023 with the VP of Regulatory Affairs revealed: -"I believe what happened was that we provided you (DHSR Surveyor) information (excel spreadsheet with incidents listed), but it was not what you wanted." -"The excel spreadsheet has the same information as the incident report." -"I think we had several people pulling information and since we have new people there was a	V 366	Incidents were requested on 5/15/2023. All IRIS and investigation packets were sent as requested on 5/15/2023. An excel spreadsheet was also sent on this day that included all Level I's within the 3-month period. The spreadsheet provides the same information as the individual incident reports.	

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V 366	Continued From page 15 communication breakdown." -Did not ensure completion of and/or provide the Risk/Cause/Analysis for incidents dated 03/10/2023 and 04/21/2023. -Did not ensure completion of and/or provide the Risk/Cause/Analysis or ensure submission of the written preliminary findings of fact to the LME/MCO within five working days for the allegations against FS #4 dated 04/10/2023 or FS #5 dated 04/11/2023. Required level I, II, and III incident reports and internal investigations (written preliminary findings of fact) were requested on 05/12/2023, 05/15/2023, and 05/19/2023. Facility incident reports were received on 05/19/2023 and required level II and III incident (IRIS) reports were never received prior to survey exit date 06/07/2023.	V 366	Investigation packet was sent to surveyor on 5/15/2023 @ 10:21am. Please see attached email dated 5/15/2023 @ 10:21am. This link included the following IRIS reports: [redacted] Surveyor noted she could not open original link sent at 10:21am. Director of Operations sent another email 5/15/2023 @ 3:47pm that included the above IRIS reports individually attached.	
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	V 367		

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V 367	Continued From page 16 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 (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	V 367	This page intentionally left blank	

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V 367	Continued From page 17 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 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 report all level II and III incidents in the Incident Response Improvement System (IRIS) and notify the Local Management Entity (LME)/Managed Care Organization (MCO) responsible for the catchment area where services were provided within 72 hours of becoming aware of the incident. The findings are:	V 367	MCO was not contacted as an allegation was not filed. The investigation result showed there was no action that warranted an allegation of abuse, neglect, or exploitation. This investigation packet was emailed on 5/15/2023 to surveyor.	

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V 367	Continued From page 18 Review on 05/19/2023 of the facility records revealed: -No IRIS reports submitted for emergency calls to dispatch Emergency Medical Technicians (EMT's) dated 03/10/2023 or the Fire Department dated 04/21/2023. -No IRIS reports or documentation of LME/MCO notifications submitted for the allegations of suspected abuse against Former Staff (FS) #4 dated 04/10/2023 and FS #5 dated 04/11/2023. Reviews on 05/12/2023 of IRIS from 02/10/2023-05/11/2023 revealed: -No IRIS reports submitted for the incidents identified above. Review on 05/19/2023 of Emailed Correspondence dated 05/19/2023 from the Vice (VP) of Regulatory Affairs to the Division of Health Service Regulation (DHSR) Surveyor revealed: -Time: 05:10 pm - 05:17 pm. -Three emails with a total of 61 facility incident reports attached. -No IRIS reports. Interviews on 05/12/2023, 05/15/2023, 05/19/2023, and 06/07/2023 with the Director of Operations revealed: -Informed to provide the DHSR Surveyor an excel spreadsheet with facility incidents listed. -Informed by executive leadership on 05/15/2023 that it would take days to gather required level II and III incident reports. -Required incident reports would be provided on 05/19/2023. -Did not complete and/or provide IRIS reports for emergency calls to dispatch EMT's dated 03/10/2023 or the Fire Department dated 04/21/2023.	V 367	3/10/2023: Error filed as non-emergency medical response. This was consumer behavior, the non-emergency transport was a Level II. Retraining will need to be completed to ensure staff are aware that this constitutes a Level II and an IRIS is to be completed. VP of Operations will retrain the Director of Operations and Nursing Manager on the definitions of incidents and what constitutes the need to file an IRIS. Notifications and appropriate timelines will also be retrained. This will be monitored ongoing by Director of Operations and VP of Operations. 4/21/2023: This was filed as an IRIS and was emailed to the state on 5/15/2023 (requested and emailed this day). Please see attached email from Director of Operations. IR-23-00688	8/29/2023

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V 367	Continued From page 19 -Did not complete and/or provide IRIS reports or notify the LME/MCO within 72 hours of becoming aware of the incidents involving allegations against FS #4 dated 04/10/2023 and FS #5 dated 04/11/2023. Interview on 05/15/2023 with the Vice President (VP) of Operations revealed: -"They are pulling the information (incident reports)." -Did not ensure completion of and/or provide IRIS reports for emergency calls to dispatch EMT's dated 03/10/2023 or the Fire Department dated 04/21/2023. -Did not ensure completion of and/or provide IRIS reports or notify the LME/MCO within 72 hours of becoming aware of the incidents involving allegations against FS #4 dated 04/10/2023 and FS #5 dated 04/11/2023. Interview on 06/07/2023 with the VP of Regulatory Affairs revealed: -"I believe what happened was that we provided you (DHSR Surveyor) information (excel spreadsheet with incidents listed), but it was not what you wanted." -"The excel spreadsheet has the same information as the incident report." -"I think we had several people pulling information and since we have new people there was a communication breakdown." -Did not ensure completion of and/or provide IRIS reports for emergency calls to dispatch EMT's dated 03/10/2023 or the Fire Department dated 04/21/2023. -Did not ensure completion of and/or provide IRIS reports or notify the LME/MCO within 72 hours of becoming aware of the incidents involving allegations against FS #4 dated 04/10/2023 and FS #5 dated 04/11/2023.	V 367	This page intentionally left blank	

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V 367	Continued From page 20 Required level II and III incident (IRIS) reports were requested on 05/12/2023, 05/15/2023, and 05/19/2023 and never received prior to survey exit date 06/07/2023.	V 367	Investigation packet was sent to surveyor on 5/15/2023 @ 10:21am. Please see attached email dated 5/15/2023 @ 10:21am. This link included the following IRIS reports: [redacted] Surveyor noted she could not open original link sent at 10:21am. Director of Operations sent another email 5/15/2023 @ 3:47pm that included the above IRIS reports individually attached.	
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications. (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall	V 500		

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V 500	Continued From page 21 identify: (1) the permitted restrictive interventions or allowed restrictions; (2) the individual responsible for informing the client; and (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention. This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to ensure all incidents of alleged or suspected abuse are reported to the County Department of Social Services (DSS). The findings are: Review between 05/12/2023 and 06/06/2023 of the facility records revealed:	V 500	This page intentionally left blank	

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V 500	Continued From page 22 -No notification to the County DSS for the allegation of suspected abuse incident dated 04/10/2023 for FC #3 against FS #4. -No notification to the County DSS for the allegation of suspected abuse incident dated 04/11/2023 for FC #4 against FS #5. Review on 05/12/2023 of the Incident Response Improvement System from 03/01/2023-05/11/2023 revealed: -No notification to the County DSS for the allegations dated 04/10/2023 for FS #4 and 04/11/2023 for FS #5. Review on 05/19/2023 of a Facility Incident Report dated 04/10/2023 for FC #3 revealed: -"Director (Director of Operations) also met with Staff [FS #4] in question. Staff denied the allegations and ultimately resigned the same day, saying it was because of the allegations." Review on 05/19/2023 of a Facility Incident Report dated 04/11/2023 for FC #4 revealed: -"She (FC #3's Guardian) also alleges [FS #5] would take [FC #4] off the floor for hours at a time." Interview on 06/07/2023 with the Director of Operations revealed: -Investigated the allegations against FS #4 and FS #5, but no additional details were provided. -Did not provide documentation to support notification to the County DSS for the allegations dated 04/10/2023 against FS #4 and 04/11/2023 against FS #5. Interview on 06/07/2023 with the VP of Operations revealed: -Allegations against FS #4 and FS #5 were investigated by the Director of Operations, but no	V 500	DSS was not contacted as an allegation was not filed. The investigation result showed there was no action that warranted an allegation of abuse, neglect, or exploitation. This investigation packet was emailed on 5/15/2023 to surveyor.	

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V 500	Continued From page 23 additional details were provided. Interview on 06/07/2023 with the VP of Regulatory Affairs revealed: -"We looked into the incidents (allegations for FS #4 dated 04/10/2023 and FS #5 dated 04/11/2023) and determined they did not rise to the level of abuse, neglect, or exploitation."	V 500		
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 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	V 537	This page intentionally left blank	

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SECU YOUTH CRISIS CENTER, A MONARCH P	1810 BACK CREEK DRIVE CHARLOTTE, NC 28213

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V 537	Continued From page 24 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. (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);	V 537	This page intentionally left blank	

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 _____	06/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 537	Continued From page 25 (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; (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	V 537	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 537	Continued From page 26 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. This Rule is not met as evidenced by: Based on record reviews and interviews, the	V 537	This page intentionally left blank	

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V 537	Continued From page 27 facility failed to ensure 1 of 3 audited staff (#1) completed initial training in seclusion, physical restraint, and isolation time out. The findings are: Review on 05/15/2023 of Staff #1's record revealed: -Hire date 01/31/2022. -No Initial Safety Care Part 2 Training in seclusion, physical restraint, and isolation time out. Interview on 05/24/2023 with Staff #1 revealed: -"I am sure I am (up to date on trainings). I had the trainings before I started in December 2022." -"I know what to do as far as de-escalation." -Was not sure if he completed Safety Care Part 2. Interview on 05/15/2023 with the Director of Operations revealed: -Staff #1 participated in an inappropriate restraint on 03/19/2023 and did not have Safety Care Part 2 Training in seclusion, physical restraint, and isolation time out. -Staff #1 was written up and no longer permitted to work at the facility as a result of the 03/19/2023 incident. Interview on 05/15/2023 with the Vice President of Operations revealed: -"He (Staff #1) had Safety Care Part 1 (Verbal De-escalation) but did not have Part 2 (Training in seclusion, physical restraint, and isolation time out)."	V 537	Staff #1 is not to permitted to work at SECU until he has taken Safety Care Part II. He has not worked at SECU since the incident. Staff are not permitted to work solo (counted in ratio) unless trained in Safety Care Part II. Program Manager and Director of Operations will ensure that all staff on the schedule have received all training required.	6/29/2023

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during the meeting.

Thank you,

[redacted]

[redacted]

Director of Operations, Crisis

[redacted] | Charlotte, NC | 28213

Direct: [redacted]

From: [redacted]
Sent: Monday, May 15, 2023 10:21 AM
To: [redacted]
Subject: SECURE: FW: [redacted] shared the folder "SECU 3 months investigation" with you.

[redacted]

Please see below...as requested here are all of the investigations for SECU done in the past 3 months.

Thank you,

[redacted]

[redacted]

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FW: SECURE

[redacted]

Thu 6/29/2023 4:00 PM

[redacted] [redacted]

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Director of Operations, Crisis
[redacted] | Charlotte, NC | 28213
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From: [redacted]
Sent: Monday, May 15, 2023 2:42 PM
To: [redacted]
Subject: SECURE

All Investigation Documents for 3 months.

Thank you,

[redacted]

FW: IRIS Reports for Last 3 Months

[redacted]

Thu 6/29/2023 3:40 PM

To: [redacted]

Cc: [redacted]

11 attachments (2 MB)

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[redacted]

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-

From: [redacted]

Sent: Monday, May 15, 2023 3:47 PM

To: [redacted]

Subject: IRIS Reports for Last 3 Months

[redacted]

Director of Operations, Crisis

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