| 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 000 | INITIAL COMMENTS<br><br>An annual, follow up, and complaint survey was completed on February 1, 2024. The complaint was unsubstantiated (NC00211961). Deficiencies were cited.<br><br>This facility is licensed for the following service categories: 10 NCAC 27G .3100 Non-hospital Medical Detoxification-Individuals who are Substance Abusers and 10 NCAC 27G 5000 Facility Based Crisis Service for Individuals of all Disability Groups.<br><br>The facility is licensed for 16 and currently has a census of 12. The survey sample consisted of audits of 2 current clients and 1 former client. | V 000 | | |
| V 220 | 27G .3103 Nonhospital Med. Detox. - Operations<br><br>10A NCAC 27G .3103 OPERATIONS<br>(a) Monitoring Clients. Each facility shall have a written policy that requires:<br>(1) procedures for monitoring each client's general condition and vital signs during at least the first 72 hours of the detoxification process; and<br>(2) procedures for monitoring and recording each client's pulse rate, blood pressure and temperature at least every four hours for the first 24 hours and at least three times daily thereafter.<br>(b) Discharge Planning And Referral To Treatment/Rehabilitation Facility. Before discharging the client, the facility shall complete a discharge plan for each client and refer each client who has completed detoxification to an outpatient or residential treatment/rehabilitation facility. | V 220 | | |

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to develop and implement a written policy that ensured vital signs for clients admitted for medical detoxification were monitored and recorded at least every four hours for the first 24 hours and at least 3 times daily thereafter affecting 1 of 2 current clients audited (#2 ) and 1 of 1 former clients audited (FC #3). The findings are:

Finding #1:
Review on 1/31/24 and 2/1/24 of client #2's record revealed:
- 26 year old female.
- Admission date of 1/26/24.
- Diagnosis of unspecified mental disorder.
- Vital Signs were not completed every four hours for the first 24 hours as required.

Review on 1/31/24 and 2/1/24 of client #2's documented vital signs from 1/26/24 - 1/27/24 revealed:
- 1/26/24 at 11:00am.
- 1/26/24 at 4:28pm (refused).
- 1/26/24 at 8:00pm.
- 1/27/24 at 8:57am.

Interview on 2/1/24 client #2 stated:
- She was admitted to the facility on 1/26/24.
- Staff checked her vital signs once during the intake process and "a few times a day" over the first two days.

Finding #2:
Review on 1/31/24 and 2/1/24 of FC #3's record revealed:

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| V 220 | Continued From page 2<br>- 33 year old male.<br>- Admission date of 1/3/24 and discharge date of 1/5/24.<br>- Diagnosis of unspecified trauma and stressor related disorder.<br>- Vital Signs were not completed every four hours for the first 24 hours as required.<br><br>Review on 1/31/24 and 2/1/24 of FC #3's documented vital signs from 1/3/24 - 1/4/24 revealed:<br>- 1/3/24 at 1:15pm.<br>- 1/3/24 at 8:00pm.<br>- 1/4/24 at 8:21am.<br>- 1/4/24 at 4:41pm (refused).<br><br>Review on 2/1/24 of the facility policy dated 6/2022, "Physical Health Screen SOP (standard operating procedure) Vital Signs" read:<br>-"Once a participant is admitted, vitals shall be taken every 12 hours (once every shift) OR as ordered by a BHMP (behavioral health medical provider)."<br><br>Interview on 1/31/24 and 2/1/24 the Licensed Practical Nurse (LPN) stated:<br>- She had worked with the facility since June of 2023.<br>- Staff documented vital signs every four hours during the first 24 hours following admission.<br>- When a client refused to have their vitals taken, documentation of the refusal was recorded.<br><br>Interview on 1/31/24 and 2/1/24 the Director stated the facility would follow up to ensure the vital signs were completed and documented as required.<br><br>This deficiency constitutes a recited deficiency and must be corrected within 30 days. | V 220 | | |

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| V 366 | 27G .0603 Incident Response Requirements<br><br>10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS<br>(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:<br>(1) attending to the health and safety needs of individuals involved in the incident;<br>(2) determining the cause of the incident;<br>(3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days;<br>(4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days;<br>(5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;<br>(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<br>(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.<br>(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.<br>(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: | V 366 | | |

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| V 366 | Continued From page 4<br>(1) immediately securing the client record by:<br>(A) obtaining the client record;<br>(B) making a photocopy;<br>(C) certifying the copy's completeness; and<br>(D) transferring the copy to an internal review team;<br>(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:<br>(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;<br>(B) gather other information needed;<br>(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<br>(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 | V 366 | | |

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| V 366 | Continued From page 5<br>LME may give the provider an extension of up to three months to submit the final report; and<br>(3) immediately notifying the following:<br>(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;<br>(B) the LME where the client resides, if different;<br>(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;<br>(D) the Department;<br>(E) the client's legal guardian, as applicable; and<br>(F) any other authorities required by law.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to document their response to level II incidents. The findings are:<br><br>See Tag V367 for specific details.<br><br>Interview on 1/31/24 and 2/1/24 the Director stated:<br>- No level II incident report had been completed for FC #3's attempted suicide.<br>- Moving forward, level II incident reports would be completed as identified in level II reporting requirements. | V 366 | | |

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| V 367 | Continued From page 6 | V 367 | | |
| V 367 | 27G .0604 Incident Reporting Requirements<br><br>10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS<br>(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:<br>(1) reporting provider contact and identification information;<br>(2) client identification information;<br>(3) type of incident;<br>(4) description of incident;<br>(5) status of the effort to determine the cause of the incident; and<br>(6) other individuals or authorities notified or responding.<br>(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:<br>(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or<br>(2) the provider obtains information required on the incident form that was previously | V 367 | | |

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| V 367 | Continued From page 7 | V 367 | | |

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 been no reportable incidents whenever no incidents have occurred during the quarter that

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| V 367 | Continued From page 8<br>meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews the facility failed to ensure critical incident reports were submitted to the Local Management Entity/Managed Care Organization (LME/MCO) as required. The findings are:<br><br>Review on 1/29/24 of the North Carolina Incident Response Improvement System (IRIS) for February 2023 - January 2024 revealed no level II reports submitted by the facility.<br><br>Review on 1/31/24 and 2/1/24 of former client (FC) #3's record revealed:<br>- 33 year old male.<br>- Admission date of 1/3/24 and discharge date of 1/5/24.<br>- Diagnosis of unspecified trauma and stressor related disorder.<br><br>Interview on 1/31/24 and 2/1/24 the Licensed Practical Nurse (LPN) stated:<br>- FC #3 was transported by emergency medical services (EMS) to a local community hospital following an attempt to take his own life.<br>- FC #3 had been scheduled to transition to another facility prior to the attempt and the local community hospital transitioned him to the other facility. | V 367 | | |

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| V 367 | Continued From page 9<br><br>Interview on 1/31/24 and 2/1/24 the Director stated:<br>- FC #3 was found in his room after an attempt to take his own life.<br>- FC #3 had been under 15 minute observation checks prior to the incident and made the attempt in-between checks.<br>- Life saving measures were implemented and FC# 3 was transported by emergency medical services (EMS) to a local community hospital.<br>- FC #3 had been scheduled to transition to another facility prior to the attempt and the local community hospital transitioned him to the other facility. | V 367 | | |
| V 536 | 27E .0107 Client Rights - Training on Alt to Rest. Int.<br><br>10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS<br>(a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions.<br>(b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented.<br>(c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered.<br>(d) The training shall be competency-based, | V 536 | | |

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| V 536 | Continued From page 10<br>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.<br>(e) Formal refresher training must be completed by each service provider periodically (minimum annually).<br>(f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.<br>(g) Staff shall demonstrate competence in the following core areas:<br>(1) knowledge and understanding of the people being served;<br>(2) recognizing and interpreting human behavior;<br>(3) recognizing the effect of internal and external stressors that may affect people with disabilities;<br>(4) strategies for building positive relationships with persons with disabilities;<br>(5) recognizing cultural, environmental and organizational factors that may affect people with disabilities;<br>(6) recognizing the importance of and assisting in the person's involvement in making decisions about their life;<br>(7) skills in assessing individual risk for escalating behavior;<br>(8) communication strategies for defusing and de-escalating potentially dangerous behavior; and<br>(9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).<br>(h) Service providers shall maintain | V 536 | | |

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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 Qualifications 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 a passing grade on testing in an instructor training program.
(3) 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.
(4) 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 (i)(5) of this Rule.
(5) Acceptable instructor training programs shall include but are not limited to presentation of:
(A) understanding the adult learner;
(B) methods for teaching content of the course;
(C) methods for evaluating trainee performance; and
(D) documentation procedures.
(6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive

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interventions at least one time, with positive review by the coach.
(7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually.
(8) Trainers shall complete a refresher instructor training at least every two years.
(j) 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 outcomes (pass/fail);
(B) when and where attended; and
(C) instructor's name.
(2) The Division of MH/DD/SAS may request and review this documentation any time.
(k) 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.
(l) 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 2 of 3 audited staff (Shift

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | MHL067-203 | A. BUILDING: _____ B. WING _____ | R 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIX CRISIS CENTER | 215-B MEMORIAL DRIVE JACKSONVILLE, NC 28546 |

| (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 536 | Continued From page 13<br>Supervisor (SS) #1 and Peer Support Specialist (PSP) #3) received training in alternatives to restrictive interventions. The findings are:<br><br>Review on 1/31/24 of SS #1's personnel record revealed:<br>- Date of hire: 9/7/23.<br>- No documentation of training in alternatives to restrictive interventions.<br><br>Review on 1/31/24 of PSP #3's personnel record revealed:<br>- Date of hire: 7/4/23.<br>- No documentation of training in alternatives to restrictive interventions.<br><br>Interview on 1/31/24 and 2/1/24 SS #1 stated:<br>- She had worked with the facility for approximately 5 months.<br>- She was scheduled to complete a training in alternative to restrictive interventions in February.<br><br>Interview on 1/31/24 PSP #3 stated:<br>- He had worked with the facility for approximately 7 months.<br>- He was scheduled to complete a training in alternative to restrictive interventions.<br><br>Interview on 1/31/24 and 2/1/24 the Director stated:<br>- She understood all staff needed current training in alternatives to restrictive interventions.<br>- Alternative to restrictive intervention training had already been scheduled in February for those that needed it. | V 536 | | |