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V 000	INITIAL COMMENTS An annual, follow up and complaint survey was completed on 5-23-24. The complaints were substantiated (#NC00215300, #NC00215250, and #NC00215303). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G 5000 Facility Based Crisis Services for Individuals of all Disability Groups. This facility is licensed for sixteen and currently has a census of ten. The survey sample consisted of audits of two current clients and one deceased client.	V 000		
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure that the HCPR registry was assessed before hire, effecting two of three audited staff (Staff #2 and Staff #3). The findings are:	V 131		

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V 131 | V 131

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Review on 4-24-24 of Staff #2's personnel record revealed:
-Start date 9-27-23.
-HCPR accessed 11-14-23

Review on 4-24-24 of Staff #3's personnel record revealed:
-Start date of 10-5-23.
-HCPR accessed 4-23-24.

Interview on 4-24-24 with the Chief Program Officer - Facility Based Crisis revealed:
-The HCPR check was late.
-She knew it should have been done before the facility let Staff #2 and Staff #3 work at the facility.

V 270 | 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 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

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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 review and interviews, the facility failed to ensure that one of three audited staff (Staff #1) received required training. The findings are:

Review on 4-22-24 of Staff #1's personnel record revealed:
-Hired 5-21-12, terminated 4-29-24.
-No training in mental illnesses, 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.

Interview on 4-22-24 with the Program Director revealed:
-Some of Staff #1's training was probably on paper since Staff #1 had been at the facility for so long.
-They could not find any record of Staff #1 having training in the required areas.

Interview on 5-17-24 with the Chief Program

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	Officer - Facility Based Crisis revealed: -They had looked, but could not find any record of Staff #1's training.			
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect	V 512		
	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. (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 and interviews one of three audited staff (Staff #1) neglected one of one deceased client (DC #1). The findings are:			

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Review on 4-3-24 of DC #1's record revealed:
-Admitted 3-18-24, died 3-19-24.
-Diagnosis of Borderline Personality Disorder.
-Assessment on 3-17-24 revealed: "current SI (suicide ideation)...feeling sad, no fun in life, no energy...nightmares/flashbacks...mood changes for no reason...Client (DC #1) reports,'I just want to hurt anyone, but I feel no empathy....Client (DC #1) denies suicidal and homicidal ideation at this time. Client reports experiencing death wishes...Client reports...'I don't want to live my life in a psych (psychiatric) ward so it would be better if I had a heart attack and go'"...
-Reassessment dated 3-18-24 "Client (DC #1) reports having current SI. Client reports 'thoughts of hurting myself'...denies having intentions of acting on his thoughts...client has avoidant eye contact and is anxious in session...Moderate Suicide Risk...Client requested to be admitted to BHUC (Behavioral Health Urgent Care) due to fear of being alone with current SI"...
-Treatment Plan dated 3-18-24 revealed: "engage in wellness and support services...utilize behavioral or cognitive skills to better manage my behavioral health...participate in daily psychoeducational and supportive interventions from the crisis team."

Review on 4-22-24 of Staff #1's personnel record revealed:
-Hire date 5-21-12.
-Termination date 4-29-24 for unacceptable job performance.
-Job description dated 6-13-23: Position title: Crisis Worker/Residential Care Staff, Provides supervision and monitoring of each consumer. Assist with and model age appropriate daily living skills.
-Trainings include: Client Rights, 6-3-19,

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Mindset, 8-21-23.

Review on 4-3-24 of the North Carolina Incident Response Improvement System (IRIS) of a dated 3-21-24 and submitted by the Center Director revealed:

-"While doing morning wake up checks, I (Staff #1) knocked on the door of the patient's (DC #1) room to prompt him to get up for vitals. Consumer (DC #1) was deceased. I looked to see what had happened and the patient had died by suicide there was a pencil laying at the top of the bed. I proceeded to alert medical staff who was on site. I then proceeded to call the Center Director. [Staff #3] is who I notified, and he (Staff #3) notified nurse, provider and EMS."

Review on 4-8-24 of the Facility's Clinical Review of a Level III Client Incident dated 3-20-24 for the incident on 3-19-24 and signed by the Chief Program Officer revealed:

-"Reviewed documentation by central nurse...interviewed and discussed his (DC #1) psychiatric symptoms as well as his history of concussions. Pt (patient) (DC #1) transported to [facility] by BHUC staff for warm hand off to ensure safety. Pt to be admitted on 15 minute checks (3-18-24)."

-"Progress note from crisis worker (Staff #1) 9pm, 3-18-24, Pt (DC #1) attended evening group, ate his snack and reported he 'felt better being here' (at the facility) and reported he had no concerns."

-"Shift note-8p-8a (3-18-24 to 3-19-24) (unknown author) Pt (DC #1) was witnessed getting up and down to go to the bathroom multiple times during the night. Pt was found at 6:10am deceased on a self-inflicted injury to his neck with what appeared to be a pen or pencil (later determined to be a coloring pencil). 911

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was called."
-Electronic bed check ends at 2:23am on 3-19-24 as the system was not available for reporting. Bed checks for the rest of the evening were handwritten and not in the electronic record.

Review on 4-9-24 of Bed Check report from 3-18-24 20:31 (8:30pm) to 3-19-24 02:23 am (2:23am) for DC#1 revealed:
-Bed checks signed approximately every 15 minutes by a staff member that was not on shift that evening.

Review on 4-22-24 of the facility video the morning of 3-19-24 revealed:
-At 1:48am Staff #2 was seen entering and exiting DC #1's room.
-At 1:53am DC #1 walked into the bathroom and walked out.
-At 2:52am DC #1 walked into the bathroom, walked out at 2:53 and was seen picking up a piece of paper and pencil from a table in the dayroom, and went back into his room.
-Staff #1 could be seen in the nurses station except for short periods of time when she was out of the camera view.
-Staff #1 was not seen walking into DC#1 room or going into any of the other client's rooms during the hours of 1:00am and 5:45am.
-No more checks on DC#1 until 5:54 when Staff #1 walked into DC#1's room and finds him deceased.

Interview on 4-10-24 with Staff #1 revealed:
-She had been employed at the facility for 13 years.
-Her job duties included: Checking on the clients every 30 minutes. "Stacking" for the next shift (making sure the next shift had food, etc ready), clean rooms, groups at 9:00 pm.

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-The clients also got night time medications, but she did not give those to the clients, that was the job of the medication technicians.
-The night of the incident on 3-19-24 "there was supposed to be two people doing my job, that night it was only me."
-Two clients came in that wanted something to eat.
-"One dude (Client) cussed me out so bad, so I made him a sandwich. I wanted to burst out in tears."
-"I also have to do a group note on each individual."
-Since she has been there it has always been everyone's job to do room checks.
-"But agency staff doesn't have that knowledge of our building. I consider it everybody's job, but we look at the crisis worker." (to do the bed checks)
-"The med techs (medication technicians) or the nurses don't have to." (do bed checks)
-"For the 15 minute checks, I'm assuming, no it would be on me." (for her to do them)
-"I asked for help and I told them that I couldn't do it. I told the med tech I was drowning."
-They had a lot of admissions that night.
- She had asked DC #1 what concerns he had before he went to bed, and was told he didn't have any.
-"I believe he stayed up till 10:30pm. I monitored him the the best of my ability."
-"I think my last time checking was 1:45am."
-The facility received more admissions during the night.
-From 2am-6am; "[Staff #2] told me at 3am she didn't go to the room to check on him (DC#1). All I can say is that I asked them to help me. I was under, I didn't have eyes on him, I didn't check on him. I thought [Staff #2] would help me, [Staff #2] wasn't doing intakes... It's like

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if I knew they were doing other things, or had they verbally told me they couldn't do them. I would have regained watching him."

-"This got so discombobulated especially after that man cussed me out. If I had known there weren't able (to help) I would have let other things go."

-"I don't know what else to say. If there had been four people one person wouldn't have left the unit at all. And I had to clean a room up. I asked the other staff for help and I feel like they thought it wasn't their responsibility."

-Since the incident happened, they are more conscious about bed checks.

-"The agency workers didn't know how things work. If we had seen him going back to the bathroom we would talk with him."

-They have not had any staff meeting since the incident on 3-19-24.

-They are more conscious of the bed checks, and they keep track of any writing utensils to make sure clients do not take them into their rooms.

Interview on 4-9-24 with Staff #2 revealed:

-She couldn't do 15 minute checks because she was in the med (medication) room.

-She is an agency worker and they have said she is now on the "Do Not Return" list because of the incident.

-She had been told that she hadn't followed protocol.

-The facility had been understaffed that evening (3-18-24) and shouldn't have admitted DC #1.

-Staff #3 had also been there. She is a medication aide and Staff #3 is a med tech (Medication Technician).

-DC #1 had told the facility that he had a plan to hurt himself.

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-The medication room where she works is in a different area from the living area
-"The Crisis Worker is the one who does the bed checks, not the med techs. Anytime I've ever worked, the Crisis Worker does the bed checks."
-Passing the medications "takes 2 hours."
-"When I checked on him (DC#1) at 3:00 he was not in his bed, he was standing up. He was pacing. I asked if I could get him something. He said he was going to try to get some sleep. I told the crisis worker. I can't get into the bed board where you document. I put a sticky note on the computer. I couldn't tell you where she was. She could have been doing laundry, I don't know. "
-Staff #3 had been doing admissions all night.
-She starts giving medications when she comes on shift, and that is her main job.
-Staff #3 was dealing with admissions and intakes.
-There was "no way" for her to check on DC#1 every 15 minutes.
-There are usually two Crisis Workers per shift, but there had only been one that night.
-When other clients have been on 15 minute checks, it is the Crisis Workers that do the checks.
-"After give meds I look through the MAR (Medication Administration Record) to make sure everything is OK. I'm pretty much stuck to that book. Not just that. I'm still passing all night. That's my job to pass meds."
-"It was [Staff #1]'s job to do the bed checks. She (staff #1) is the crisis worker and she is supposed to do bed checks. I don't think it is her fault. It had to be between 5-6 am and at that time I was flagging the MAR the to get ready for morning med pass."

Interview on 4-9-24 with Staff #3 revealed:
-He is a med tech and makes sure they are

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getting their medications or he is doing admissions.
-"Bed checks are the Crisis Workers responsibility and to up date the bed board (when bed checks are recorded), that is not our responsibility."
-DC #1 had been getting up several times throughout the night.
-The facility had four admissions that night, so he was taking care of those.
-Normally there are 2-3 crisis workers but that night, just one (Staff#1).
-He did all the intakes by himself.
-He told Staff #1 that DC #1 was using the bathroom too frequently, that he would only be in the bathroom approximately 30 seconds then come back out.
-Staff #3 believed DC #1 had been seeing who was watching him.
-It was the Crisis Workers job to do the bed checks.
-He spoke with the Program Director about the fact that it was the Crisis Workers job to do the bed checks.
-Staff #1 went outside for a smoke break after telling him she had done the bed checks.
-Staff #1 walked in and found DC#1 approximately 6:10am and called me over.
-DC#1 had blood all over his shirt. Staff #1 made the determination that DC #1 was deceased.
-He looked for DC #1's chest rising, but his pupils were constricted.
-They called 911 and upper management.
-The nurse came in and put her gloves on to check for a pulse, but he was deceased.
-"It was impossible to check on him every 15 minutes, we had our job duties as well."

Interview on 4-12-24 with Nurse #1 revealed:

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-She had not seen the video of the morning on 3-19-24.
-She did know that DC #1 was supposed to be checked every 15 minutes.
-It was a doctors order to have him get checked every 15 minutes.
-"It's everybody's responsibility to do bed checks. The med techs and the Crisis Workers both are responsible."
-The majority of the time, they do have two crisis workers, but they only had one that night.

Interview on 4-3-24 with the Program Director revealed:
-DC #1 came from BHUC. That is a 24 hour crisis placement that clients can go to be assessed. Once they are there, the BHUC facility will find out what facility's have beds.
-The BHUC staff had brought DC#1 over straight from the BHUC facility.
-DC #1 was on 15 minute checks per doctors order.
-They had watched the video and she had seen staff conducting checks.
-The staff that left earlier that evening had forgotten to sign out of the bed check board, so that is why the bed checks that were recorded were signed by a staff that wasn't working at the time.
-They bed check board went down because of all the new clients being admitted.
-We don't know when the last check was, but he was found approximately 6:00 am.
-At night they have 2-4 staff, that night it was two med techs (Staff #2, Staff #3) and a crisis worker (Staff #1).
-The med techs were from an outside agency but had received all of the facility training.
-They have had several meetings about facility changes after the incident, but Staff #1

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had not been at them.
-They also have meetings at 8:00am and 8:00pm daily to go over the clients and who gets 15 minute bed checks and Staff #1 would have attended those.

Interview on 5-17-24 and 5-20-24 with the Chief Program Officer - Facility Based Crisis revealed:
-"[Staff #3] was the only one that I could understand (Not doing bed checks). He was doing four admissions in a row. The other two not so much."
-It is the Crisis Workers job, but other staff are to assist if the Crisis Worker is unavailable. In this case the Crisis Worker was available and Staff #2 would have no reason to do the bed checks.
-They put the majority of the blame on Staff #1.
-"If she (Staff #1) was doing other things it was her responsibility to let her team know to check." (bed checks)
-It was also the Program Director job to ensure that Staff #1 had attended the meetings that were held after the incident.
-"We have terminated [Staff #1] after looking at the video. It became clear, she just did not do her job."

Review on 5-21-24 of the Plan of Protection dated 5-21-24 and signed by the Chief Program Office revealed:

"1. What immediate action with the facility take to ensure the safety of consumers in your care?
a. Termination of responsible staff involved: 4/29/24.
b. Replaced writing instruments with pliable options to decrease self-harm possiblity: 3/25/24-

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL090-169	A. BUILDING: ________ B. WING ________	R 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE CRISIS RECOVERY CENTER	1408 EAST FRANKLIN STREET MONROE, NC 28112

(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
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4/9/24.

c. Collect all writing/painting utensils prior to consumers retiring at the end of the day, having instruments checked out through the day unless is a group activity: 3/25/24.

d. Implementation of an electronic alert if if a safety check is missed, email goes to the center director 4/14/24.

e. Ensured every FBC has a dedicated ipad for recording safety checks. 3/20/24

f. Met with staff at every facility to review the safety check protocols and reason why they are crucial to patient care: 3/22/24-4/9/24

g. Met with center Directors to direct them on needing monitoring of the bed board to ensure safety checks were happening consistently and on time. 3/7/24

h. Updated the patient safety protocol to reflect current directives on completing bed checks and the management of instruments that could be used to self harm: 4/1/24

i. Reviewed with Daymark (Licensee) staff how to record safety checks in the electronic system and how to record if the system is down: 3/22/24-4/9/24

j. Ensured that all contracted agency staff understand the safety check protocol and how to record them in the electronic system. 4/2/24.

k. Directed all staff to log out of the ipads at the end of their shift to ensure the current staff on duty is documented as recording the safety checks. 3/21/24

l. Chief Program Officer-FBC and Regional Directors met with all human services clinicians to review suicidality, risk factors, protective factors, and professional responsibility in intervening/responding to patient with suicide ideation. 4/14/24

m. Medical Director met with all perscribers to review suicidality, risk factors, and professional

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responsibility in intervening/responding to patients with suicide ideation. Discussed the need to be diligent in observing the environmental factors and implements that could be used for self-harm. Encouraged prescribers to provide continual training and support to staff on the topic of patient safety protocols. 5/2/24

n. Medical Director reviewed the importance of accurate shift reports reflecting timely and accurate information for prescribers and all staff to keep up with individual patient status and need. 5/2/24

o. Explore the ability to use a scan gun on the door or armband of the patient. This is to ensure a check is done. Need to research the feasibility through researching the products available, cost and availability of such tools. 7/1/24

p. Research patient monitoring tools that might monitor the movement or vitals that may be available, accessible and not cost prohibitive. 7/1/24

q. Development of a daily document of patients indicating the number and frequency of safety checks for Center directors to review to ensure checks are being made as ordered. 7/1/24

r. Direct all management to ensure all relevant staff attend center wide meetings and trainings. 5/28/24

2. Describe plans to make sure the above happens.

a. Letters a-n have been completed.

b. Letters o-r are already in progress via IT creating a tracking document and management actively searching for an alternative manner to accurately record bed checks.

DC #1 admitted on 3-18-24 was transported to the facility by BHUC (Behavioral Health Urgent

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Care) staff for a warm hand off to ensure safety. DC#1 was admitted on 15 minute checks for his safety. During an assessment on 3-17-24 the client reported current suicide ideation and feeling sad. During a reassessment on 3-18-24 continued SI was reported and the assessment listed DC#1 as a Moderate Suicide Risk. During the 3-18-24 reassessment, DC#1 requested to be admitted to BHUC due to fear of being alone with current SI. DC#1 told staff that he had a plan to hurt himself, per staff report, but stated he had no intentions of acting on his thoughts. Staff #1 was responsible for completing the 15 minute bed checks. According to video footage Staff #2 was seen going into DC#1's room at 1:48am. Staff #3 reported he saw DC#1 going into the bathroom several times. DC #1 can be seen in the video footage at 2:52am going into the bathroom and then was seen picking up a piece of paper and pencil from a table in the dayroom, and went back into his room. Staff #1 did not complete any bed checks on DC#1 from 1:00am to 5:45am. DC#1 was found dead by staff #1 at 5:54am. DC#1 committed suicide by sticking a pencil into his neck. The facility had several meetings after the incident to discuss client safety, but Staff #1 was not in attendance. Staff #1 was terminated on 4-29-24. This deficiency constitutes a Type A1 rule violation for neglect and must be corrected within 23 days.