STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20140058	A. BUILDING: _____ B. WING _____	09/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVORIAL CENTER	3200 WATERFIELD DRIVE GARNER, NC 27529

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An Annual and Complaint Survey was completed 09/25/18. The complaint was unsubstantiated (Intake #NC00142722). Deficiencies were cited. This facility is licensed in the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents.	V 000	*Please note that Strategic Behavioral Center – Raleigh takes these findings seriously and is fully committed towards developing effective strategies for compliance with regulations and monitoring and evaluation activities to ensure compliance with same.* *Pursuant to your request, the corrective actions are delineated in the following pattern:*	
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations;	V 105	*a) The procedure for preventing the deficiency and implementing the acceptable plan of correction for the specific deficiency identified;* *b) The date by which all corrective actions will be completed, and the monitoring system will be in place.* *c) The title of the person responsible for implementing the acceptable plan of correction* *d) The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements.*	

DHSR - Mental Health
NOV 14 2018
Lic. & Cert. Section

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rachel Beal

TITLE: CEO

(X6) DATE: 11/12/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20140058	A. BUILDING: _____ B. WING _____	09/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVORIAL CENTER	3200 WATERFIELD DRIVE GARNER, NC 27529

(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 105	Continued From page 1 (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field; This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure serious occurrences were reported to the Protection and	V 105	Begin V105 **a) The procedure for preventing the deficiency and implementing the acceptable plan of correction for the specific deficiency identified:** The Director of Quality, Compliance, and Risk Management (DQCR) had mistakenly been informed to only report information asked for during a Disability Rights of North Carolina (DRNC) investigation. 1)The DQCR has been re-educated on requirements related to reporting serious occurrences to both the State Medicaid agency and DRNC. It has been emphasized that this report must be made no later than close of business the next business day after each serious occurrence, as defined in 483.352. 2) Hospital leadership have been educated on the requirement that serious occurrences, as defined in 483.352, shall be reported to the DQCR immediately, in her absence, the CEO, to ensure that the reporting requirement of a report to Medicaid and DRNC no later than close of business the next business day is upheld. In order to remain on the schedule, staff not in attendance for the training are required to receive training on this requirement prior to any scheduled work by the completion date. V105 continued below	**b)** 11/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20140058	A. BUILDING: _____ B. WING _____	09/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVORIAL CENTER	3200 WATERFIELD DRIVE GARNER, NC 27529

(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 105	Continued From page 2 Advocacy system as required. The findings are: Per the Code of Federal Regulations (CFR) 483.374(b), the facility "must report to both the State Medicaid agency and the Protection and Advocacy system (Disability Rights of North Carolina (DRNC)) no later than close of business the next business day after each serious occurrence. Reportable serious occurrences include...b. A serious injury to a resident as defined in 483.352 (Any significant impairment of the physical condition to the resident as determined by the qualified medical personnel. This includes, but is not limited to, burns lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self inflicted or inflicted someone else.)...Staff must document that each serious occurrence was reported to both the state Medicaid agency and the state designated Proection and Advocacy system." I. Review on 09/11/18 of client #004701's record revealed: - Admitted: 06/11/18 -15 year old male - Diagnoses: Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder by History and Reactive Attachment Disorder by History -No documentation of injuries reported to DRNC Review on 09/12/18 of the facility's occurences reported to North Carolina Incident Report Improvement System (IRIS) by the Director of Risk Management and Compliance included: - On 09/03/18, client #004701 was attacked by three of his peers (clients #004861, #004618, and #001007) on his unit (700). Client #004701 was sent out to local hospital and evaluated for bleeding in his right ear. This report was	V 105	V105 Continued **c) The title of the person responsible for implementing the acceptable plan of correction:** The Director of Quality, Compliance, and Risk Management **d) The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements:** 1)Compliance with the requirement to report to the State Medicaid Agency and DRNC no later than close of business the next business day will be monitored as follows: The DQCR will present information on any serious occurrences, as defined in 483.352, to the CEO on a M-F basis. The DQCR shall present evidence to the CEO that the report to the State Medicaid Agency and DRNC has been made no later than close of business the next business day by comparing and showing the date/time the hospital was made aware of the incident to the date/time the report was made. The DQCR will document that this review has occurred. Compliance with this requirement will be addressed through the progressive disciplinary action process. 2) Evidence of the DQCR's compliance with reporting requirements will be reported daily in the Hospital's Morning Meeting. The findings, conclusions, recommendations, and actions taken will be aggregated and forwarded by the Director of Quality/Compliance/ Risk to the Hospital's monthly Quality/PI Council, Medical Executive Committee and quarterly Governing Board at each of their respective meetings. This process will continue as presented on a go-forward basis and has no end date.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20140058	A. BUILDING: _____ B. WING _____	09/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVORIAL CENTER	3200 WATERFIELD DRIVE GARNER, NC 27529

(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 105	Continued From page 3 submitted on 09/10/18. Review on 09/11/18 of local hospital report dated 09/03/18 revealed: "-Diagnoses: Closed head injury, initial encounter. Contusion of auricle of ear, unspecified laterality, initial encounter Perforation of right tympanic membrane. Ruptured ear drum." II. Review on 09/11/18 of client #004428's record revealed: -Admitted: 04/04/18 -17 year old male -Diagnoses: Crohn's Disease, Attention Deficit Hyperactivity Disorder and Conduct Disorder -No documentation of injuries reported to DRNC Review on 09/11/18 of the local hospital report dated 06/28/18 for client #004428 revealed: "-Diagnoses: Concussion with loss of consciousness, Abrasion of face, Head injury and Dental Trauma." III. Review on 09/11/18 of client #003361's record revealed: -Admitted: 03/14/18 -17 year old male -Diagnoses: Sex Offender, Attention Deficit Hyperactivity Disorder, Combined Type, Unspecified Bipolar Disorder and Post Traumatic Stress Disorder -No documentation of injuries reported to DRNC During observation and interview on 09/24/18 at approximately 1:00 PM, client #003361 revealed: -An orange and yellow full cast on right hand from fingers to the elbow. -He had hurt his arm by trying to break a window on the hall	V 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20140058	A. BUILDING: _____ B. WING _____	09/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVORIAL CENTER	3200 WATERFIELD DRIVE GARNER, NC 27529

(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 105	Continued From page 4 Interviews on 09/24/18 and 09/25/18 with Director of QA (Quality Assurance) Risk reported: - Occurences noted above had not been reported to DRNC. - Previously, she had been informed by the representative at DRNC "only report the information asked for during her (DRNC's) investigation."	V 105		
			Begin V118	
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR	V 118	**a) The procedure for preventing the deficiency and implementing the acceptable plan of correction for the specific deficiency identified:** All nursing staff with medication administration responsibilities are being re-educated on the requirement that the Medication Administration Record (MAR) must be kept current. Medications administered shall be recorded immediately after administration and include the name or initials of the person who administered the drug. In order to remain on the schedule, staff not in attendance for the training are required to receive training on this requirement prior to any scheduled work by the completion date. **c) The title of the person responsible for implementing the acceptable plan of correction:** Director of Nursing **d) The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements:** 1) On a daily basis, the Director of Nursing, or trained delegate, will review the previous day's MARs to audit for the requirements related to medication administration records.	**b)** 11/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20140058	A. BUILDING: _____ B. WING _____	09/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVORIAL CENTER	3200 WATERFIELD DRIVE GARNER, NC 27529

(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 118	Continued From page 5 file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on interview and record review, the facility staff failed to assure all MAR's were kept current affecting four of four current audited clients (#004750, #004618, #004428, and #001007). The findings are: Review on 09/11/18 of Client #004750's record revealed: - Admitted: 07/17/18 -12-year-old male -Diagnosis: Disruptive Mood Disorder -Medications prescribed included but not limited to: Physician's order dated 07/18/18 Synthroid (used to treat thyroid related issues)75 mg once daily 1-2 hours before meals and Melatonin (sleep aid) 3 mg one tablet at night Review on 09/11/18-09/25/18 of client #004750's July-September 2018 MARs revealed no initials to indicate medications were administered: -August: Synthroid (16th & 17th) -September: Synthroid (1st); Melatonin (17th) Review on 09/11/18 of client #004618's record revealed: -Admitted: 08/22/18 - 13 year old male -Diagnoses: Post Traumatic Stress Disorder, Borderline Diabetes -Medications prescribed included but not limited to: Physician's orders dated 09/03/18 listed Metformin (can treat Diabetes and behavioral	V 118	V118 Continued 2) Bi-weekly the Director of Nursing, or trained delegate, will observe a medication pass on every shift to assess if the requirements related to medication administration are being followed. Nursing staff not meeting these requirements will be addressed on a progressive disciplinary basis. The findings are reported daily in the Hospital's Morning Meeting. The findings, conclusions, recommendations, and actions taken will be aggregated and forwarded by the Director of Quality/Compliance/ Risk to the Hospital's monthly Quality/PI Council, Medical Executive Committee and quarterly Governing Board at each of their respective meetings. This process will continue as presented on a go-forward basis and has no end date.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20140058	A. BUILDING: _____ B. WING _____	09/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVORIAL CENTER	3200 WATERFIELD DRIVE GARNER, NC 27529

(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 118	Continued From page 6 issues) 500 mg one tablet twice a day, Vitamin B6 (supports nervous system) 50 mg daily, Zoloft (antidepressant) 50 mg one tablet daily and Guanfacine (can treat Hypertension and Attention Defecit Hyperactivity Disorder) 1 mg one tablet twice daily. Review on 09/11/-09/25/18 of client #004618's August-September 2018 MARs revealed no initials to indicate medications were administered: -September: Metformin (10th- AM dosage); Vitamin B6 (8th, 10th, 18th, & 19th), Zoloft (10th), Melatonin (22nd), Guanfacine (22nd-PM dosage) Review on 09/11/18 of client #004428's record revealed: -17 year old male. -Admission date of 04/04/18. -Diagnoses of Crohn's Disease, Attention Deficit Hyperactivity Disorder, Conduct Disorder. Review on 09/11/18 of client #004428's record revealed the following Physician orders: 04/06/18 -Multivitamin (vitamin supplement) Take 1 tablet by mouth 1 time a day. 05/14/18 -Clindamycin 1% solution (treat severe acne) Apply to affected area's of acne twice daily until clear. 04/04/18 -Humira 40mg/0.8ml (treat many inflammatory conditions) Give every 3 weeks. -Melatonin 5mg (treats short-term regulation of sleep patterns) Give 2 tablets at bedtime. -Sertraline 50mg (treats depression) Give 1 tablet by mouth at bedtime. 07/16/18 -Minocycline 50mg(treats acne) Twice a day for 2 weeks for acne.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20140058	A. BUILDING: _____ B. WING _____	09/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVORIAL CENTER	3200 WATERFIELD DRIVE GARNER, NC 27529

(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 118	Continued From page 7 Review on 09/11/-09/25/18 of client #004428's June and July 2017 MAR's revealed the following blanks: -Multivitamin-06/03/18, 06/23/18. -Clindamycin-06/03/18, 06/23/18, 06/30/18, 07/13/18, 07/28/18. -Humira-07/26/18. -Melatonin-06/30/18, 07/28/18. -Sertraline-06/30/18, 07/28/18. -Minocycline-07/17/18, 07/18/18, 07/19/18. Review on 9/11/18 of client #001007's record revealed: -16 year old male. -Admission date of 08/23/17. -Diagnoses of Bipolar, Attention Deficit Hyperactivity Disorder, Post Traumatic Stress Disorder, and Oppositional Defiant Disorder. Review on 09/11/18 of client #001007's record revealed the following Physician orders: 08/24/18 - Docusate SOD (treats constipation) 100mg take 2 capsules by mouth two times a day. - Fluticasone Prop 50 Miepileptic)CG S (sterioid) give 1 spray in each nostril every morning for allergies every morning. - Melatonin 3mg (Sleep) 3 capsules at bedtime Review on 9/11/-09/25/18 of client #1's MAR for August 2018 MAR revealed blanks on the following date: - Fluticasone Prop 50 MCG - 8/8/18 (8:00 am) - Docusate SOD 100mg.- 8/6/18 (2:00 pm) - Melatonin 3mg - 8/24/18 and 8/26/18 During interview on 09/25/18, Registered Nurse #3 reported: -A blank on the MAR would indicate either	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20140058	A. BUILDING: _____ B. WING _____	09/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVORIAL CENTER	3200 WATERFIELD DRIVE GARNER, NC 27529

(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 118	Continued From page 8 someone forgot to initial or a client refused. -If a client refused medications, documentation regarding refusal would be documented on the reverse of the MAR During interview on 09/25/18, the Director of QA (Qualiliy Assurance) Risk reported: -Medication Administration Records should be monitored daily by the nursing staff -Since June 2018, the facility was in transition for a Director of Nursing	V 118		
V 315	27G .1902 Psych. Res. Tx. Facility - Staff 10A NCAC 27G .1902 STAFF (a) Each facility shall be under the direction a physician board-eligible or certified in child psychiatry or a general psychiatrist with experience in the treatment of children and adolescents with mental illness. (b) At all times, at least two direct care staff members shall be present with every six children or adolescents in each residential unit. (c) If the PRTF is hospital based, staff shall be specifically assigned to this facility, with responsibilities separate from those performed on an acute medical unit or other residential units. (d) A psychiatrist shall provide weekly consultation to review medications with each child or adolescent admitted to the facility. (e) The PRTF shall provide 24 hour on-site coverage by a registered nurse. This Rule is not met as evidenced by:	V 315	Begin V315 **a) The procedure for preventing the deficiency and implementing the acceptable plan of correction for the specific deficiency identified:** 1) A daily review of staffing coverage for all shifts is now being reported to the Hospital's Morning Meeting of leadership staff. Shifts out of compliance with staffing are addressed through PRN coverage or leadership assisting with any deficits in same. 2) Whenever there is a patient event requiring a Root Cause Analysis, the adequacy of staffing is assessed to determine if staffing might have been a factor in the occurrence or prevention of same. **c) The title of the person responsible for implementing the acceptable plan of correction:** Director of Nursing	**b)**10/18/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20140058	A. BUILDING: _____ B. WING _____	09/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVORIAL CENTER	3200 WATERFIELD DRIVE GARNER, NC 27529

(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 315	Continued From page 9 Based on record reviews, observations and interviews the facility failed to meet minimum staffing requirements. The findings are: Finding #1 Review on 09/11/18 of client #004701's record revealed: -15 year old male. -Admission date of 06/11/18. -Diagnoses of Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder by History, Reactive Attachment Disorder by History. Review on 09/11/18 of the North Carolina Incident Response Improvement System report dated 09/03/18 revealed: "-On 09/03/18 at approximately patient [004701] was attacked by three of his peers on his unit (700). The peers that attacked him are [004861], [004618], and [001007]. The [004701] was sent out to [Hospital] for evaluation d/t (due to) bleeding in his right ear." Review on 09/11/18 of local hospital report dated 09/03/18 revealed: "-Diagnoses: Closed head injury, initial encounter. Contusion of auricle of ear, unspecified laterality, initial encounter Perforation of right tympanic membrane. Ruptured ear drum." Review on 09/25/18 of the facility's video surveillance of the incident on 09/03/18 revealed: -12 clients entering the hall. -2 staff with the clients. -1 staff leaves the hall and enters the nursing station leaving one staff on the hall. -Client #004701 was pushed out of a bedroom at the end of the hall. -Client #004701 began walking down hall and	V 315	V315 continued **d) The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements:** 1) On a daily basis, the Director of Nursing is now reporting on compliance with staffing requirements for all nursing staff units. 2) The findings are reported daily in the Hospital's Morning Meeting. The findings, conclusions, recommendations, and actions taken are being aggregated and forwarded by the Director of Quality/Compliance/ Risk to the Hospital's monthly Quality/PI Council, Medical Executive Committee and quarterly Governing Board at each of their respective meetings. This process will continue as presented on a go-forward basis and has no end date.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20140058	A. BUILDING: _____ B. WING _____	09/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVORIAL CENTER	3200 WATERFIELD DRIVE GARNER, NC 27529

(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 315	Continued From page 10 was attacked by 3 other consumers while only one staff was on the hall. -Second staff re-enters hall along with nursing staff and a male staff to end the fight. During interview on 09/24/18 client #004701 revealed: -He was living on 700 hall. -He got "jumped" by 3 other clients. -He was in an argument with his roommate. -Another consumer started yelling at him and he told him to "shut up." -The client he was yelling at and two other consumers started hitting him. -He was bleeding from both of his ears. -He had to be taken to the hospital. -He did not see any staff when he was getting beat up. -A nurse took him off the hall. During interview on 9/24/18, client #004861 revealed: -He had resided at the facility on unit 700 for one month. -Had improved his anger management. -He had fought client #004701 once during a touch football game and a second time when the client called him and peers by racial slurs. -He and other peers "got" client #004701. -During the second fight he remembered three staff working the unit that day but did not know their names. -A "code purple" was called and other staff came to the unit to break up the fight. During interview on 9/24/18, client #001007 revealed: -He had been at the facility a year and one month.	V 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20140058	A. BUILDING: _____ B. WING _____	09/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVORIAL CENTER	3200 WATERFIELD DRIVE GARNER, NC 27529

(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 315	Continued From page 11 -He got into a fight with client #004701 because he was disrespectful to black women and stole from him. -Staff were taking client #001701 from the hall when he said, "I'm tired of y'all black b---." -He assaulted client #004701 and other peers "jumped in too." -Usually three staff work on the unit; "there were not enough staff that day." -Staff #4 and a nurse were working when the fight occurred; they called a "code purple" (when extra assistance is needed due to a behavior) and other staff came. -Client #004701 was hurt and bleeding; another peer fell but was not injured. During interview on 09/25/18 staff #4 revealed: -She worked on the 700 hall of the facility. -The 700 hall had 12 clients. -Only 2 to 3 staff work on the hall. -She was working the night the incident occurred with client 004701. -A staff had told her to keep an eye on client 004701 because of other client's planning something against him. -Only 2 staff were on the hall that evening. -She was on the hall by herself because the other staff had gone into the documentation station . -Client #004701's roommate was upset with him and tripped him or pushed client #004701 into the hall. -3 other client's began attacking client #004701. -She called a Code Purple (when extra assistance is needed due to a behavior). -After she watched the video she felt then she should have done more. -She did not know what to do because the boys are big on the hall and she was by herself. During interview on 09/25/18 staff #3 revealed:	V 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20140058	A. BUILDING: _____ B. WING _____	09/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVORIAL CENTER	3200 WATERFIELD DRIVE GARNER, NC 27529

(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 315	Continued From page 12 -She was a prn (as needed) staff. -She mainly worked on the 400 hall but she had also worked on the 700 hall. -She was working the night of the incident with client #004701. -She was not as familiar with the clients because she had not worked that hall often. -The incident occurred after the client's had returned to the hall from the gym. -She had gone to the nurses station. -She went back on the hall when she saw the fight with client #004701 and 3 other consumers. -Client #004701 was crying and was taken off the hall to the nurses station. -A staff was on break so the hall only had two staff. -A Code Purple was called and other staff came on the hall to help with the fight. Finding #2 Review on 9/25/18 of client #004313's record revealed: -13 year old male. -Admission date of 8/16/18. -Diagnoses of Attention Deficit Hyperactivity Disorder combined type, Unspecified Impulse Control Disorder, Conduct Disorder and Rule Out Post Traumatic Stress Disorder. During observation on 09/25/18 revealed: - at 10:38 AM, on 900 hall, client #004313 was walking unsupervised; a moment later, Mental Health Technician #1 (MHT) entered the hall and explained the client appeared lethargic in class and would be taken to be assessed During interview on 09/25/18 the Mental Health Technician #1 revealed: -He mostly worked the 400 hall. -Client #004313 was struggling with English.	V 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20140058	A. BUILDING: _____ B. WING _____	09/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVORIAL CENTER	3200 WATERFIELD DRIVE GARNER, NC 27529

(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 315	Continued From page 13 -The teacher asked client #004303 to lift his head off the desk. -He and Teacher #2 were the only staff in the classroom. -He had stepped away from the classroom to get water for another client just leaving the teacher with the clients. -When he returned to the education hall client #004313 was in the hall. -The 400 hall had 12 clients. -3 staff work on the hall but we should have 4. -When the clients transition from one location of the facility to another we should have 4 staff but usually only have 2 staff. -He would ask the nurse to assist at times to keep the ratio but they are not always available to assist. -If a Code Purple is called in the facility other staff from the halls are pulled to help with the Code Purple putting the other halls out of ratio. Finding #3 The following reflects several observations in which appropriate staffing was not maintained. Observations on 9/25/18 revealed: -Between 10:05 and 10:10 AM, outside of units 500 and 600, ten clients escorted onto a unit accompanied by two staff. -Between 10:05 to 10:20 AM, outside of units 500 and 600, ten clients escorted off a unit accompanied by two staff. During an interview on 09/24/18 the Milieu Manager #1 revealed: - Each wing if fully staffed had four to five staff per shift. -"In the event of an emergency or crisis we send an announcement (Code Purple) throughout the facility alerting the identified staff to respond to	V 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20140058	A. BUILDING: _____ B. WING _____	09/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVORIAL CENTER	3200 WATERFIELD DRIVE GARNER, NC 27529

(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 315	Continued From page 14 the crisis. There are times we are short staffed, making it difficult to have enough staff to be full on each wing." - "Most Managers and RC's (Resident Counselors) are on the Code Purple Team each shift. There are times we are not fully staffed. We are currently trying to work on staffing issues ." During interview on 09/25/18 the Director of Quality Assurance (QA) revealed: -The staffing expectation is to meet ratio of 2 staff per 6 clients. -If a unit was full with 12 clients it should have 4 staff. -When transitioning clients in the facility the same staff and client ratio should remain. During interview on 09/25/18 the Chief Executive Officer (CEO) revealed: -She began her position in April at the facility. -The facility since had been going through a transition due to a "disconnect" between services. -The transition would lead to a more nursing led approach. -The transition would consist of 1 nurse and 4 Mental Health Technicians on a unit. -The transition would create better relationships and better supervision. -After reviewing the incident with client #004701 it was an "affirmation" the transition was going to be better for each unit. Review on 09/25/18 of the Plan of Protection dated 09/25/18 and completed by the CEO revealed: "-What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? CEO, Compliance Director and Milieu Managers to immediately audit staffing for the current shift ,	V 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20140058	A. BUILDING: _____ B. WING _____	09/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVORIAL CENTER	3200 WATERFIELD DRIVE GARNER, NC 27529

(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 315	Continued From page 15 and allocate Handle With Care (HWC) trained leadership team members if necessary to fill any gaps in staffing. Effective immediately and until further notice, Milieu Managers will do a headcount of assigned MHT staff at the time clock as they arrive and immediately report tardy arrivals or no-shows to the House Supervisor and Administrator On Call (AOC). The AOC will be responsible for immediately reallocating appropriately trained team members, including therapists, admissions counselors, and appropriately credentialed leadership team members to patient care vacancies until they can be relived by a PRN team member. Effective immediately and until further notice, the Code Purple response team is to be comprised of the House Supervisor and Milieu Managers. On night shift there will be an additional designated therapist/counselor from the A&R/Call Center Team, and during the day shift a team member will be allocated from the Clinical Services Team. -Describe your plans to make sure the above happens. The AOC will conduct daily audits to check ratios and address immediately by reallocating staff as necessary with the CEO's authority. CEO will personally round at shift change for the next 72 hours to ensure that shift-change headcount is in place as described and then hand-off responsibility to the AOC to verify ratios through in-person and video monitoring. CEO will meet with House Supervisors, Milieu Managers, and other designated staff to communicate Code Purple expectations. CEO	V 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20140058	A. BUILDING: _____ B. WING _____	09/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVORIAL CENTER	3200 WATERFIELD DRIVE GARNER, NC 27529

(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 315	Continued From page 16 and AOC will verify that appropriate Code Purple team members are verified on the daily assignment sheets." Due to the facility's practice of understaffing units, client #004701 was attacked by three peers (clients #004861, #004618, and #001007). Census on the unit was 12 clients at the time of the incident. Video footage showed one staff on the unit which was not enough to manage the situation. As a result, client #004701 sustained serious injury to his head and ear. The facility's failure to meet minimum staffing requirements constitutes serious neglect and is a Type A1 rule violation and must be corrected within 23 days. An administrative penalty of $3000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 315		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility was not maintained in a clean and orderly manner. The findings are: Observation and tour of the facility on 09/10/18 between 11:45 AM and 1:00 PM yielded:	V 736	Begin V736 **a) The procedure for preventing the deficiency and implementing the acceptable plan of correction for the specific deficiency identified:** 1) A new Director of Plant Operations is now in place at the facility. This Director of Plant Operations is skilled in all associated environment of care requirements. 2) All housekeeping and direct care staff have been re-educated on the expectation that the facility and grounds be maintained in a safe, clean, attractive, and orderly manner and shall be kept free from offensive odor, as stated in 27G.0303. In order to remain on the schedule, staff not in attendance for the training are required to receive training on this requirement prior to any scheduled work by the completion date. **c) The title of the person responsible for implementing the acceptable plan of correction:** Director of Plant Operations	**b)** 1) 9/18/18 2) 11/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20140058	A. BUILDING: _____ B. WING _____	09/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVORIAL CENTER	3200 WATERFIELD DRIVE GARNER, NC 27529

(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 736	Continued From page 17 -5 units (300, 400, 500, 600 & 700 hallways), licensed to serve up to 60 clients for PRTF services....6 separate bedrooms on each unit....each bedroom on every unit was toured..more than 30% of the bedrooms were unkept, beds not made, clothing items on the bedroom floor. Observation of 300 hall revealed: - a strong odor of urine throughout the unit - rust and black mold noted in bathroom shower area of room 300 - low water pressure in bathroom of room 304 During an interview on 9/10/18, the staff conducting the tour could not identify what the odor was. Observation of 400 hall revealed: - soiled feminine hygiene products on wall rail in bathroom of room 400 - trash on floor and writing on walls of room 401 - a mattress leaning against the wall and torn carpet in room 402 - carpet torn in room 403 - torn carpet at the entry way of room 404, paint peeling on the window sill and along the wall - low water pressure in bathroom of room 405 Observation of 500 hall: - water covering the floor of bathroom of room 503 - cracks in the bathroom floor covered with duck tape in room 505 - a foot long crack in the wall of the hallway - torn cushions on the sofas in the day room - worn and dirty areas in the carpet of day room and throughout the unit Observation of 600 hall revealed:	V 736	V736 Continued **d) The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements:** On a daily basis (M-F), the Director of Plant Operations, or trained delegate, will conduct rounds in all resident care areas to ensure that areas are safe and clean and free from offensive odors. On the weekends, these rounds will be accomplished by the House Supervisor, or trained delegate. These rounds will be augmented by MHT staff who are to assess patient care areas for cleanliness prior to the start of each shift. Any areas found out of compliance will be reported immediately and addressed by housekeeping to bring into compliance. Evidence of these requirements will be reported daily into the hospital's Morning Meeting of leadership.. The findings, conclusions, recommendations, and actions taken will be aggregated and forwarded by the Director of Quality/Compliance/Risk to the hospital's monthly Quality/PI Council, Medical Executive Committee, and Governing Board at each of their respective meetings. This process will continue as presented on a go-forward basis and has no end date.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20140058	A. BUILDING: _____ B. WING _____	09/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVORIAL CENTER	3200 WATERFIELD DRIVE GARNER, NC 27529

(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 736	Continued From page 18 - no seat cushions on the sofas in the day room - holes in wall and outside door of room 604 - soiled towel and toilet paper in bathroom of room 605 During an interview on 9/10/18, staff reported the sofa cushions were being cleaned. Observation of 700 hall revealed: - the water temperature in the bathroom of room 700 was 99 degrees Fahrenheit - there was no bathroom tissue and dirty commode in the bathroom of room 701 - the water temperature in the bathroom of room 702 was 92 degrees Fahrenheit - in room 703 there was a yellow substance on the ceiling and walls and a brown substance smeared on the bathroom wall; the water temperature in the bathroom was 92 degrees Fahrenheit - walls and ceiling had discoloring (red and yellow) spots in room 704 - water pressure was low on the bathroom of room 705 During an interview on 9/10/18, the staff could not identify the substances on the ceiling or walls.	V 736		

STRATEGIC
BEHAVIORAL CENTER

November 12, 2018

NCDHHS/NCDHSR
Mental Health Licensure and Certification Section
India Vaughn -Rhodes
2718 Mail Service Center
Raleigh, NC 27699-2718

Re: Annual and Complaint Survey completed September 25, 2018.

Dear Ms. Vaughn-Rhodes:

Please see the attached Plan of Correction that I am submitting on behalf of Strategic Behavioral Center-Garner. We would like to ensure you that we take these findings seriously and is fully committed toward developing effective strategies for compliance with regulations and monitoring and evaluation activities to ensure compliance with the same. We are dedicated to providing quality care for our patients.

Respectfully,

Rachel Beal

Rachel Beal, CEO

Enc: Plan of Correction

qsj

3200 Waterfield Drive ◆ Garner, North Carolina 27529
P (919) 800-4400 ◆ F (919) 573-4163