

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601361	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 02/04/2019
NAME OF PROVIDER OR SUPPLIER SECU YOUTH CRISIS CENTER, A MONARCH P		STREET ADDRESS, CITY, STATE, ZIP CODE 1810 BACK CREEK DRIVE CHARLOTTE, NC 28213		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint and follow up survey was completed on 2/4/19. The complaints were substantiated (NC00145486 & NC00147432). Deficiencies were cited. This facility is licensed for the following service category: 27G .3100 Non-hospital Medical Detoxification and 27G .5000 Facility Crisis Services for all Disability Groups.	V 000	DHSR - Mental Health MAR 12 2019 Lic. & Cert. Section	
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	V 118	Upon admission, Client #4 received doctor's orders for seven days. Client #4 was scheduled to be discharged on the date the order expired. The discharge date was changed, and current orders were not obtained for FC #4. The Program Director will retrain all nurses on the need to obtain current orders for all clients in the facility to ensure that all medications are administered as prescribed. The Program Director/Designee will review MARs daily. The VP of Operations will monitor on a weekly basis. Target date: 03/23/2019	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

8899

F8F411

If continuation sheet 1 of 31

Dresh A. Gushin MSW, LSW VP Operations 3/8/19

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V 118	Continued From page 1 checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure medications were administered to a client on the written order of a person authorized by law to prescribe drugs affecting 1 of 1 former client (FC#4). The findings are: Review on 1/17/19 of FC #4's record revealed: - admission date of 12/21/18 with discharge date of 12/31/18; - diagnoses of Conduct Disorder, Moderate, Disruptive Mood Dysregulation Disorder, Cannabis Use Disorder, Moderate, Stimulant-Related Disorder Amphetamine-type, moderate; - Psychiatric Diagnostic included physicians' orders for Lithium Carbonate 300mg (2) QHS dated 12/22/18; - FC #4 was not administered the above medication on 12/28-30/18 per Medication Administration Record (MAR); Interview on 1/17/19 with Vice President of Operations revealed: - FC#4 was admitted to the facility with Lithium Carbonate 300mg; - after review of MAR, confirmed FC #4 had not received his Lithium on 12/28-30/18; - doctor wrote prescriptions for 7 days only; - unsure reason night shift nurse had not administered FC #4's Lithium Carbonate since the facility kept stock medications of Lithium	V 118			

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V 118	Continued From page 2 Carbonate 150mg; - will discuss with medical staff.	V 118			
V 269	27G .5001 Facility Based Crisis -Scope 10A NCAC 27G .5001 SCOPE (a) A facility-based crisis service for individuals who have a mental illness, developmental disability or substance abuse disorder is a 24-hour residential facility which provides disability-specific care and treatment in a non-hospital setting for individuals in crisis who need short-term intensive evaluation, or treatment intervention or behavioral management to stabilize acute or crisis situations. (b) This facility is designed as a time-limited alternative to hospitalization for an individual in crisis. This Rule is not met as evidenced by: Based on record review and interview the facility neglected to provide individuals in crisis with treatment interventions to stabilize acute or crisis situations affecting 3 of 3 Former Clients (FC#1, #2, #3). The findings are: Interview on 1/10/19 with the facility's Medical Director/Child Psychiatrist (MD/CP) revealed: - Facility staff made all attempts to de-escalate clients to keep them at the facility but if there was imminent danger or if staff could not talk them down or the medications did not help, they would send clients out to the hospital; - She (MD/CP) or the on call MD gave the verbal orders to send clients out. - The facility did not use restraints, seclusion, or intramuscular medications (IM's), however	V 269	The Program Manager will retrain all staff on treatment strategies to assist individuals in acute or crisis situations. Monarch's Restrictive Intervention policy will be reviewed. Specifically, staff will review the need to use the least restrictive intervention warranted. Based on the individual's behavior, staff will implement restrictive interventions to ensure the safety of clients when necessary. A debriefing will be completed within 24 hours of all emergency discharges from the SECU. The Program Director/Designee will ensure that appropriate treatment interventions were completed to assist the individual in crisis. Additionally, the emergency discharge was only completed when interventions were not successful in maintaining a safe environment for the client(s). Target Date: 03/22/2019		

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V 269	Continued From page 3 Vistaril/Benadryl and Saphris were administered. Interview on 1/19/19 with a Registered Nurse (RN) revealed: - Before anyone would get hurt, it was a safety concern, therefore the facility would send the clients out to the hospital. The medications they gave to the clients did not work, e.g. Saphris (sublingual) takes 1-2 hours to work, po (orally) medications had no results, injections were not given and there was no seclusion room. Cross Reference: 10A NCAC 27G .5002 Staff (V270) Based on record review and interview the facility failed to provide additional staff to provide more intensive supervision, treatment or management in response to the needs of individual clients for 3 of 3 FC's (#1, #2, #3) clients. The findings are: Cross Reference: 10A NCAC 27G . 5003 Operations (V271) Based on record review and interview the facility failed to develop and protocols and procedures for discharge planning for all clients sent out to the hospital affecting 3 of 3 FC's (#1, #2, #3). The findings are: Review of the Plan of Protection dated 2/4/19 written by the VP of Operations revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? .5001 and .5002 - The SECU Youth FBC will continue to be in compliance with 1:3 staffing ratio as required. The Program Director will monitor the schedule on a daily basis. .5003 Operations - The clinical team (Program Director/Lead Therapist) will create an Emergency Discharge Plan/Process for clients who are discharged to the Emergency	V 269			

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V 269	Continued From page 4 Department. This will be monitored by the Lead Therapist. .0209 Medication Requirements - Clients will receive all ordered medications and the medication administration record will be monitored daily by the Program Director. Describe your plans to make sure the above happens. VP of Operations, will monitor the above weekly to ensure compliance." From June 2018 to January 2019, there were 21 clients between the ages of 6-15 who were admitted to the "time limited alternative to hospitalization" facility to receive short-term intensive evaluation, or treatment intervention or behavioral management to stabilize their acute or crisis behaviors. According to the clients clinical assessments they met the criteria to be admitted to the program with diagnoses and behaviors including but not limited to Oppositional Defiant Disorder, Substance Abuse Disorder, verbal/physical aggression, and property damage. However 1-2 days after the clients were admitted to the facility approximately 10 of the 21 clients were sent to the hospital for the same types of behaviors they had been admitted for, while the other clients were sent to the hospital 3-6 days after admission. Staff interviews confirmed the facility could not manage their crisis behaviors due to not implementing the appropriate interventions and not having additional staff in place to provide more intensive supervision (e.g. 1:1), treatment. In addition staff acknowledged that clients who posed immediate threats to themselves or others were sent to the hospital because they were unable to manage the behaviors. When clients were sent to the hospital, the facility did not send staff to accompany the clients, did not provide pertinent information about their diagnoses, history, or behaviors, and did not follow up with the hospital	V 269			

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V 269	Continued From page 5 once clients arrived. This compromised the ability of the Emergency Department to effectively meet the needs of clients in crisis. In addition they did not coordinate care with the legal guardian to assure the most appropriate individualized treatment and transition planning if the client was unable to return to the facility. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of \$3,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of \$500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 269			
V 270	27G .5002 Facility Based Crisis -Staff 10A NCAC 27G .5002 STAFF (a) Each facility shall maintain staff to client ratios that ensure the health and safety of clients served in the facility. (b) Staff with training and experience in the provision of care to the needs of clients shall be present at all times when clients are in the facility. (c) The facility shall have the capacity to bring additional staff on site to provide more intensive supervision, treatment, or management in 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	V 270	The SECU Youth FBC will continue to be in compliance with 1:3 staffing ratio as required. Additionally, upon admission, the FBC will evaluate each child to determine appropriate supervision needs. If escalating behaviors are noted at admission/upon initial presentation, the FBC will obtain a dr. order to provide 1:1 staffing or constant observation. The Program Manager will provide general training for staff to deepen their understanding of the FBC requirements and appropriate staffing ratios. The Program Manager/Designee will monitor the schedule daily to ensure appropriate staff ratios for the individuals receiving service. Target Date 03/23/2019		

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V 270	Continued From page 6 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 interview the facility failed to provide additional staff to provide more intensive supervision, treatment or management in response to the needs of individual clients for 3 of 3 Former Clients (FC#1, #2, #3) clients. The findings are: Interview on 1/14/19 with Hospital Administration Staff revealed: - Communication with Emergency Medical Services (EMS) reported the facility staff acknowledged to them (EMS) the clients "can't come back" and the facility's reasons for sending the clients to the hospital were based on the lack of adequate staffing on site versus client behaviors, therefore when the clients arrived at the hospital they were "taking up room's just housing clients". Interviews on 2/4/19 with facility staff revealed: - Staff client ratio was an ongoing problem; some clients needed 1:1 staffing depending on the severity of the behaviors or even medical issues; The facility environment became "more dangerous out of ratio." - One staff reported the client ratio was 1:3, another staff reported 2:4;	V 270			

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V 270	Continued From page 7 - One staff reported nurses were a part of the staff client ratio, another staff reported nurses were not a part of the staff client ratio; - Facility did not use seclusion or restraint; - Facility used interventions such as verbal redirection, processing, music, phone calls and isolation; - Facility sent clients out to the hospital when staff could not control "dangerous behaviors", "violence and aggression over the top" which were posed an immediate threat to themselves, peers or staff; - If clients were immediate threats they were sent out and the Medical Doctor (MD) had to give the order and approve before 911 was called and a client was transported by EMS to the hospital; - Staff meetings were held to address staff client ratio however the issue continued; - Staff client ratio would become problematic having to work with clients on the units and intakes simultaneously, sometimes administration had to fill in; - Pro re nata (PRN) staff lists were available however the staff would have to be called in and it could not guaranteed the person would pick up the shift; - The additional staff needed to already be in place in addition to the required staff client ratio; - Staff worked 12 hour shifts with clients who had unpredictable behaviors and staff "get beat up" but you can't not take them, so staff encounter frustration and burn out. This deficiency is cross referenced into 10A NCAC 27G .5001 Facility Based Crisis Scope (V269) for a Type A1 rule violation and must be corrected within 23 days. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 270			

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V 271	27G .5003 Facility Based Crisis -Operations 10A NCAC 27G .5003 OPERATIONS (a) Each facility shall have protocols and procedures for assessment, treatment, monitoring, and discharge planning for adults and for children of each disability group served in the facility. Protocols and procedures shall be approved by the area program's medical director or the medical director's designee, as well as the director of the appropriate disability unit of the area program. (b) Discharge Planning and Referral to Treatment/Rehabilitation Facility. Each facility shall complete a discharge plan for each client that summarizes the reason for admission, intervention provided, recommendations for follow-up, and referral to an outpatient or day program or residential treatment/rehabilitation facility. This Rule is not met as evidenced by: Based on record review and interview the facility failed to develop protocols and procedures for discharge planning for all clients that were sent out to the hospital affecting 3 of 3 Former Clients (FC's #1, #2, #3). The findings are: Record review on 1/9/19 of client census and assessments inclusive of all clients who were sent out to the hospital from the facility revealed: - From June 2018 to January 2019, 21 former clients were "sent out" in that they were transported by Emergency Medical Services (EMS) from the facility to a hospital for behavioral issues. - The clients who were "sent out" ranged in ages from 6-15 years old, diagnosed with but not limited to Oppositional Defiant Disorder (ODD),	V 271	The Program Manager will provide training to the RNs and therapists on the SECU discharge process. This training will include the completion of the SCEU ***Monarch Report form and Discharge Summary. The training will also incorporate the need to document/provide the following information for all emergency transfers: • Presenting problem • Custody • Discharge diagnosis • Medications and current MARs. • Legal guardian contact information • Phone contact with ED The Program Manager/Designee will monitor completion of the discharge process at the debriefing. Target Date: 03/23/2109		

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V 271	Continued From page 9 Attention Deficit Hyperactivity Disorder (ADHD) to Substance Abuse (SA) Disorder, while their behaviors included but were not limited to physical and verbal aggression, property damage, stealing, running away. - The former clients on the census were documented as "coded Psych" with the exception of one client documented as "general illness." Record review on 1/9/19 of FC #1's record revealed: - Admitted to the facility on 11/14/18 and sent out to the hospital on 11/15/18; - FC #1 did not return to the facility; - Age 6; - Initial Comprehensive Clinical Assessment dated 11/14/18 - "6 year old ...mobile crisis referred [FC #1] to facility consequent to increased aggression and risk taking behavior. Legal Guardian [LG] reports he runs off ...disruptive behaviors persisting at home and school ...current medications to do seem effective ...she (LG) further disclosed that [FC #1] does not sleep well even with medication and is up at night 'standing in the doorway' and other times 'screams out at night' and 'walks the floor a lot at night' ...history of head banging the back of his head when upset, phases of self isolating, property damage ...provided photos of damage ...stutters really bad and can't talk when nervous or anxious ...Treatment recommendations is admission to facility to ensure safety as evidenced by providing a secure and monitored facility with therapeutic milieu and psychiatric medication evaluation that serves to promote decreased aggression and risk-taking behavior, improved sleep, and attention/inhibition ..."; - Treatment plan dated 11/14/18 included diagnoses of ODD, Severe and ADHD, Severe. Problems Included working on behavior	V 271			

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V 271	Continued From page 10 compliance, safe behavior, attention/focus and consistent sleep. Clinical team members interventions included but were not limited to designing developmentally appropriate and culturally sensitive interventions that take into account unique strengths, needs and difficulties, using the most effective, evidence based practices to address psychiatric symptoms, teaching client #1 to use effective coping skills and consulting with clinical supervisor and/or treatment team, as needed, in order to provide the most clinically appropriate treatment available. Psychiatric Care Team interventions included but were not limited to providing psychiatric (medication) evaluation, monitoring, administration (e.g. injections) and management every 2-12 weeks, and/or as clinically indicated, to evaluate the appropriateness for and to monitor medications prescribed to assist with symptom management, assisting with Patient Assistance Programs as appropriate. Record review on 1/9/19 of FC #2's record revealed: - Admitted to the facility on 10/7/18 and sent out to the hospital on 10/8/18; - FC #2 did not return to the facility; - Age 13; - Initial Comprehensive Clinical Assessment dated 10/7/18 "...four failed placements within the last few months due to continued behaviors of stealing, lying and running away ...sexually abused ...[FC #2] reports seeing and hearing things that aren't there ...set a fire at a bowling alley as well as set his bed on fire ...Clinician assesses the [facility] as the appropriate level of care to enhance safety and coordinate follow up services ... Based on this assessment, [FC #2] meets the following diagnosis(es): ...Kleptomania ...Intellectual developmental	V 271			

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V 271	Continued From page 11 disability (IDD) Moderate, ADHD, Combined presentation, Moderate ..." - FC #2 present at the facility less than 24 hours therefore no treatment plan developed. Record review on 1/9/19 of FC #3's record revealed: - Admitted to the facility on 10/16/18 and sent out to the hospital on 10/20/18; - FC #3 did not return to the facility; - Age 14; - Initial Comprehensive Clinical Assessment dated 10/16/18 " ...presented to the facility due to disruption of respite placement involving police after verbal and threatening physical aggression ...history of elopement ...nightmares ...waking up in the middle of the night to sneak food. Clinician assess the facility as the appropriate level of care to enhance the safety and aid in coordinating follow up) services ..." Record review on 1/9/19 revealed facility Policy's and Procedure's: "PROGRAM: Behavioral Health Facility Based Crisis Program SECTION: Intake, Admission and Discharge TOPIC: Discharge Procedure DATE ISSUED/UPDATED: 10/17 ...Purpose: The purpose of this procedure is to provide clear, consistent, and concise guidelines for clinical staff to ensure that the individual's rights are protected and adequate education and instruction provided during any type of discharge from the program. Scope: This procedure applies specifically to Facility Based Crisis Units operated by [Monarch]. Procedure: Scheduled Discharge Procedure: 1. Staff psychiatrist/nurse practitioner/physician assistant will give discharge order. 2. Staff psychiatrist/nurse practitioner/physician assistant will order supply of discharge medication and/or determine that the person supported has	V 271			

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V 271	Continued From page 12 sufficient medication supply, if appropriate. 3. Person supported and/or guardian will be notified of discharge date and time. 4. The person's person centered crisis plan will be updated at the time of discharge with the individual supported and family/significant others and a copy given to the person supported/guardian. 5. A referral will be made for follow up with an appropriate treatment resource of the person's choice. If this provider is not the person's primary provider, then the primary provider will be notified. 6. At the time of discharge, aftercare planning will have been completed, with the involvement of the person supported or their representative, and documented in a written plan. This plan will address medication needs, a crisis plan, and any other recommendations made by staff. 7. All of the person's personal items will be returned to as he/she leaves the facility ...Referral for Emergency Medical Treatment. For persons supported who need emergency hospital care/evaluation that may or may not have a primary health care provider, the following procedures should be followed: 1. 911 should be called immediately, and First Aid or Cardio-Pulmonary Resuscitation (CPR) should be administered until help arrives on the scene. 2. The Registered Nurse (RN) on duty will advise and consult with assigned medical provider as soon as possible. 3. Any pertinent information will be completed by the nurse and sent with the person supported. 4. Any discharge involving a referral for an emergent or urgent medical issues, will be reviewed and approved by the staff psychiatrist/nurse practitioner/physician assistant and the receiving facility shall be given necessary information pertinent to the transfer and the conditions upon which the person supported may return. 5. The staff psychiatrist/nurse practitioner/physician assistant will provide the	V 271			

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V 271	Continued From page 13 discharge order ...discharge orders will be documented by the nurse on duty ...Staff psychiatrist/nurse practitioner will provide medications orders, if appropriate ...Staff will complete Aftercare Plan with the person supported/guardian at time of discharge, both staff and person supported/guardian will sign plan ...will be provided a copy ...person supported/legal guardian will sign a receipt for personal items ..." "PROGRAM: All Section: Intake Admissions and Discharge TOPIC: Discharge/Transfer ...DATE ISSUED/UPDATED: ...3/20/17 ...POLICY: It is the policy of Monarch to establish discharge/transfer criteria and procedures pertinent to all programs, sites and services ...A transfer is defined as the temporary movement of an individual between facilities of the same type, temporary movement from a licensed site to a psychiatric or medical hospital ...increase/change in service for the individual which results in contact with new staff. If an individual moves from one location to another then it will be treated as a discharge from the location and admission to the new location. A discharge is defined as a permanent movement of an individual to another facility/setting which operates independently from the current facility/setting or complete discharge from the agency. Discharge/transfer may occur due to one or more of the following reasons: -Individual's needs can be better met in an alternate, but same type, site for a short period of time. -The individual no longer meets eligibility/entrance and continued stay requirements or now meets discharge criteria for a service ...The person's service needs have increased or decreased from what is currently provided. -Individual is experiencing acute symptoms which require a more intensive level of care. -Individual's needs	V 271			

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V 271	Continued From page 14 have changed and no longer can be met by the agency ...Individual has presented gross risk to an employee and/or the organization and can no longer effectively be served by the agency while maintaining the safety of others, and after appropriate referrals have been made. -The individual consistently fails to meet rules of the program. -Individual requires a different environment/provider ...Or any other reason that is in the best interest of the individual ...The agency will follow all guidelines or rules/regulations established in the licensing definitions in the Mental Health/Developmental Disabilities/Substance Abuse Services (MH/DD/SAS) Rules ...For discharges/transfers, the agency must complete a discharge summary that is located in the individual's record. Discharge summary is required when treatment is no longer necessary or no longer meets the need. Discharge Summary form is to be completed as part of the Discharge Plan at the time of discharge. Elements to include the following: -Reason for admission. -Course and progress of the individual in relation to the goals and strategies in the Person Centered Plan (PCP) or service plan. -Condition of the individual at discharge. -Recommendations and arrangements for further services or treatment. -Discharge diagnosis. -Aftercare/Transition Plan. -Reason for Discharge/Program Closure. -Disposition. -Dated signature ...The agency must provide a reasonable time to prepare the individual and his/her guardian and parents for the change (except in emergencies). This can be done by involving these individuals in the planning, providing services to assist the individual in preparing for the change and involving these individuals in any decision about the change since this decision is generally part of a team process ...In emergencies, individuals may be	V 271			

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V 271	Continued From page 15 discharged from services in timeframe's less than those specified by policy, regulation or funding contract. In most cases, discharge initiated by the agency for emergency will be due to a health and/or safety reason. When an individual will be discharged, a plan shall be developed, which is included on the discharge program closure form, to meet the individual's needs following discharge, shall be sufficient enough to allow any receiving service provider to provide the services and supports needed by the individual in order to adjust to the new situation and contain recommendations for further services. The plan will be developed as soon as practical but no later than the date of discharge. With the consent of the individual or his/her legally responsible person, the professionals responsible for the plans shall contact appropriate representatives at the individual's destination or in his/her home community before formulating the recommendations. This plan will be reviewed and revised as needed so that the most current information is reflected at discharge. A copy of the plan shall be furnished to the individual or to his/her legally responsible person and, with the consent of the individual, to the individual's next of kin. A plan may not be required when it is not feasible because of an unanticipated discontinuation of the individual's treatment ...PROCEDURES...4. The qualified professional and/or designee shall ensure by assisting the individual that the information outlined in this policy, and any other information requested by the service provider, is shared at the time of transfer ...7. When a discharge/transfer occurs under emergency situations, the qualified professional shall be available to the caregiver, provider, etc. in order to provide information for the individual's success ..."	V 271			

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V 271	Continued From page 16 "PROGRAM: All. SECTION: Treatment and Habilitation. TOPIC: Coordination of Care. DATE ISSUED/UPDATED: 9/15/17 ...Policy:...to provide Coordination of Care to all individuals supported by our programs where this process is needed or required. Coordination of Care allows the individual to receive a level of care that is specific to that individual needs. The level of Coordination of Care will vary depending on service definition requirements and the individualized need of the person receiving services. Please reference specific definitions and clinical coverage policies for specific services requiring this process. PROCEDURE: When indicated, [Monarch] will communicate and coordinate care with other professionals providing care to the individual. Monarch shall document coordination of care activities. The following are examples of coordination of care activities: -Written progress or summary reports; -Telephone communication; ...Other care coordinating efforts including but not limited to linkage to community resources, Medicaid state plans services, school based services, discharge planning, medical care and housing ...Situations in which care coordination may be indicated include but are not limited to: -When an individual presents to [Monarch] following a recent hospitalization ...-When an individual supported by Monarch is hospitalized while receiving services ..." Record review on 1/10/18 and 1/14/19 of two Hospital Emergency Departments (ED) documentation revealed: - "[FC #1] ...Final Report ...November 15, 2018 ...ED Note ...pt (patient) arrived via EMS from [monarch] ...Pt is a 6 y/o ...presenting to ED from [Monarch] wherein he was apparently upset and aggressive at the facility. He apparently cried	V 271			

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V 271	Continued From page 17 after a ball was taken from him. EMS stated that he was crying in the corner, but easily consoled. No apparent injuries. Grandmother/Legal Guardian [LG] who is here, is unaware of the events that occurred ...Medical Decision Making. PT is well in appearance from a medical standpoint. Unclear as to the underlying issues for which the patient has presented. PT will have eval (evaluation) by Psych social worker (SW) prior to determining final dispo. Psych SW stated that patient was extremely aggressive, hitting head on walls and self injury. He is not toxic in appearance presently, however, pt will require admission for further psych stabilization as patient is apparently unable to be cared for at [Monarch] ... Medication list. Medication Information Obtained From: Patient/family. Medication Status: Incomplete med list; advised to bring med/med list..." - "[FC #1] ...Final Report... November 16, 2018 ...Telepsych Consultation... Pt's grandmother states she is not sure if pt has been discharged from [Monarch] as the reason why he was admitted there was for the particular behaviors that he was exhibiting and she thought the psychiatrist there was going to proceed with a plan for med changes that was discussed yesterday...Pt has not been aggressive or tried to hurt self while in the E.R. (emergency room) Recommend pt stay in ER observation for now. Grandmother [LG] will call to talk with [Monarch] psychiatrist and administration today to see if he is able to return. She thinks something may have been going wrong with the evening staff ...She thought putting him in the [Monarch] residential program would be the answer but he was only there one day and now he is here in the ED. She described does not sleep, he walks the floor all night long until about 4am....Grandmother does	V 271			

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V 271	Continued From page 18 not know what to do at this point, she is requesting help in getting pt the right care ...Telepsychiatry Clinician Assessment. cc: 'I don't know.' 6 year old ...transported to hospital ER via EMS. Patient had only been a day at the residential treatment program at [Monarch] when the staff there called an ambulance allegedly due to patient trying to hurt himself ...nurse at [Monarch] reported that patient had been crying and screaming all day and had been inconsolable. She alleges that they were not allowed to restrain the patient and so they had difficulty calming him down. She alleges that the patient started banging his head on the floor. She also relates that patient had tried to hit a staff member and another resident ...Grandmother [LG] was told by the evening nurse that patient was not going to be able to return to [Monarch]. She states that she was surprised to hear this because she had spoken through the day with the treating psychiatrist as well as other day staff and they had been letting her know that patient had been restrained and secluded and that the doctor discuss new medication adjustments ...She states that the doctor did not say anything to her about the patient needing to go to the hospital or being discharged from the facility. Grandmother [LG] states that it taken quite some time to get patient in the facility and that she had given them lots of his records. Prior to patient starting the [Monarch] program, he was having frequent aggressive episodes at school. She also had reported that the patient did not sleep well and that he was hyperactive ...[Monarch] nurse reported Their program is voluntary only so pt's behavior warranted a higher level of care ..." - "[FC #1] ...Final Report ...November 17, 2018 ...Telepsych Consultation ...6 year old ...brought into the emergency department yesterday after he began acting out during his first day in a program	V 271			

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V 271	Continued From page 19 at [Monarch]. The [Monarch] personnel were unable to control the patient and transferred the patient to the emergency department. His [FC #1] legal guardian who is his grandmother states that she called [Monarch] and they stated that he is not allowed to return to the program at this time ...Spoke with the grandmother [LG] she stated that she called [Monarch] yesterday and tried to speak with the administrator to find out if he would be allowed to return to their program. Her call was transferred to the charge nurse who informed her that the pt was discharged from their program. If she would like him to be admitted, he would have to go thru the admission process again ...frustrated by that information. She stated she spent 4 hours with them to get him admitted there. She had met with [MD] who told her that they could manage his aggressive behaviors and head banging behaviors at their program. She does not understand why they were able to restrain him and manage his behaviors all day but not able to handle him in the evening. He was simply put in the ambulance and sent to the ED. She has also not received clarification about whether he was given his medication by the nurse at [Monarch]but they never called her back ...Attempted to reach [Monarch] staff to verify that they are not going to allow this pt to return to their program, but unable to reach anyone. There was generic voice message option available, no message left because it did not have the program name or any staff name mentioned on the voice mailbox. It was a transfer from the greeting to an unknown voice mailbox..." - "[FC #2] ED Admit date: 10/8/18. Presented to ED for: Brought from Monarch, altercation, punching, screaming at staff. Where they admitted from: Was a patient at [a hospital]	V 271			

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V 271	Continued From page 20 10/2-10/7. Discharged (DC) to [Monarch] and brought for behaviors (after father refused to pick him up at [Monarch]. Barrier to DC: Father (adoptive) refuses to pick patient up in ED; & states wanted to relinquish rights. Adoptive Mother also states this and living in Florida. Department of Social Services (DSS) obtained guardianship ...DC Date & Plan: ... DSS found temporary placement 10/22. Length of Stay (LOS): 15 days." "[FC #3] ED Admit date: 10/20/18. Presented to ED for: Brought from [Monarch], verbally assaulting staff. Where they admitted from: Resident at [Monarch] youth Crisis Center. DSS is legal guardian. Barrier to DC: DSS to establish new placement. [Monarch] sent without any information. RN & CCM staff called multiple times for patient (pt) information. Medic quoted that at pickup pt "is acting out and we don't have enough staff here tonight for this. DC Date & Plan: 10/26 to foster placement in [another city]. LOS: 7 days." Review on 1/31/19 of Emergency Medical Services (EMS) call documentation revealed: - Comments documented for 21 former clients from June 2018 - January 2019 transported to the hospital included but were not limited to "Pt agitated. No Guardian Info given ...Pt agitated and hitting walls. Hurt hand ...name given as guardian but no one signed for pt transport ...outburst because she doesn't want to be at [Monarch]. Guardian listed but no signature obtained ...Pt destroyed room because she wants to be with her mom and not at [Monarch]. Guardian listed but no signature ...Pt has headache with facial droop. Guardian listed but no signature ...Staff stated that pt was violent with staff and non-compliant with meds. Pt is lying	V 271			

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V 271	Continued From page 21 calmly in bed and does not know that he is being transported to the hospital nor why. No guardian info ...Pt drawing on walls and throwing stuff around room. Pt states she is acting out due to flashbacks. guardian listed but no signature ...Pt agitated by staff and started to kick and hit things. Pt calmed in the back of ambulance and was cooperative once removed from the situation. No guardian listed ...Pt agitated after a call with his father went poorly and started throwing things. Pt cooperative with EMS. Guardian listed but no signature ...Pt bit and kicked another resident. Not violent toward EMS [Program Director listed as guardian and signed] ...Pt became aggressive with staff. Pt. is aggressive but not violent with EMS. No guardian listed. EMS tried calling 3 contact number for DSS social worker but no contact made. Staff very withholding with information on pt ...Pt had assaulted a staff member and was being expelled from the program. Pt was combative and tried to assault EMS. Guardian listed as father but no signature ...Pt emotional and unable to be calmed after toy taken from him. Guardian listed but no signature ...Pt was acting inappropriately but no violent nor suicidal. Pt listened and followed EMS instruction. Not able to get a hold of DSS Worker. Staff states that both its parents and DSS worker wanted him transferred to [a hospital]. We cannot transport to [a hospital] so pt transported to hospital. [Program Director] listed as guardian and signed ...Staff stated pt was becoming aggressive and yelling that she didn't belong there. Pt being sent to the hospital for a psych eval. Guardian listed as pt mother but no signature ..." - 9 out of the 21 clients EMS transported to the hospital were sent with personal belongings described for one client as "clothing", one client as "Paper bag of belongings, one client as	V 271			

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V 271	Continued From page 22 "Medications" one client as "2 bags, medication and facility paperwork and one client as "books, 2 paper bags, clothing and shoes" one client as "bag", one client as "bag" one client as "bag" and one client as "bag." Interview 1/16/19 with FC #1's LG revealed: - FC #1 was court ordered to receive facility crisis services because the courts and school felt she (LG) did not have enough support and resources for FC #1. - At intake she spoke to the facility's Social Worker (SW) about FC #1's problems, she met with the psychiatrist for about 2 hours and returned later the same day of admit from 6-7pm to visit and he was doing fine. Staff assured her the facility was able to meet his (FC #1's) needs. The first night FC #1 stayed at the facility, they called her at 2am and reported he wasn't sleeping and was jumping off the furniture and had been given a pro re nata (PRN) medication Benadryl. Second day during the evening on 2nd shift the second shift nurse called her and reported FC #1's aggression was too much, in that, he was running back and forth in the long hallway banging his head. Six hours later she was called and informed he (FC #1) was being sent to the hospital by EMS. The facility nurse who called to inform her he (FC #1) was on the way to the hospital gave her no details on what occurred with FC #1 and was screaming at her, telling her she needed to get off the phone asking questions and meet the ambulance at the hospital with him (FC #1), specifically "you talking to me and you need to get off this phone and go meet the ambulance." She then asked what hospital and who was riding with FC #1 and the nurse told her no one was riding with him (FC #1). She could hear the "ambulance attendant" asking where she was and while the nurse responded she (LG) was	V 271			

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V 271	Continued From page 23 in [a city outside of the facility's location], she corrected the nurse telling her she resided in [a city outside of the facility's location]. The ambulance attendant then received permission to transport FC #1 closer to her, which was in [a city outside of the facility's location]. She arrived at the hospital, where EMS had waited on her on her to arrive and reported to her they were not sure of the reason he (FC #1) was transported because he was not irate or physically aggression he was only screaming when they arrived to the facility. She then asked EMS if he could be transported back to the facility and EMS told her the facility said he was discharged. She then called the facility to speak to the charge nurse but she was not available and while the person on the phone thought she placed her (LG) on hold she had not and heard another person screaming for the unit secretary to hang up the phone "he was discharged." The facility never called her to follow up about any recommendations, she was given no paperwork/referrals, "no support at all, no help no guidance." Aftercare plans were made for FC #1 with the help of the hospital staff and the Managed Care Organization (MCO). She (LG) called and scheduled a time to pick up his (FC #1's) belongings and when she arrived, no staff asked where FC #1 was or how FC #1 was doing, "nothing." Interview on 1/10/19 with the facility's Medical Director/Child Psychiatrist (MD/CP) revealed: - Job duties included but were not limited to the review of referrals, clinical assessments, psychiatric evaluations, coordination with families/outside agencies and participation in treatment team meetings; - She made the final decision as to who was admitted and/or declined to the facility; - She or the on call MD gave all verbal orders for	V 271			

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V 271	Continued From page 24 clients to be sent out to the hospital; - Facility did not use restraints, seclusion, or Intramuscular medications (IM's), however de-escalation and the medications Vistaril/Benadryl and Saphris were administered; - Facility staff made all attempts to keep the clients at the facility but if there was imminent danger, or if staff could not talk them down or the medications did not help those clients were sent out to the hospital; - Clients had usually calmed down by the time EMS arrived; - Facility staff would call the receiving charge nurse however that communication was not documented, therefore could not be confirmed; - The facility did not use any type of form to document client information to be sent with EMS or given to the hospital emergency department or the LG; - Facility communication had not been documented consistently for clients who were sent out to the hospital emergency department or the LG, but thought some nurses may have documented on the nursing notes that a client had been "sent out," but was not sure; - Clients who were discharged from the facility were followed up with written documentation such as external agencies, crisis plans, and respite resources; - Clients who were sent out to the hospital did not receive discharged follow up documentation; - After clients were transported by EMS or the police they were in their custody and once they arrived at the hospital they were in the custody of the hospital, where IM's could be administered; - Facility staff notified the legal guardians prior to clients being transported to the hospital but it was up the LG's to get to the hospital to meet the client because facility staff did not accompany clients to the hospital; unsure if EMS were	V 271			

Division of Health Service Regulation

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V 271	Continued From page 25 required to speak to the LG during this process; - "Sent out" process described- Technician and Administration greet EMS or police, processing is attempted and/or transported and/or IM given. The facility would then give EMS a list of medications and the form with information on it. Also technician gathered clients belongings from their lockers and medication list because the "hospital has a pharmacy" the facility did not send medications with EMS or police. She was not sure if client medications had ever been sent with EMS, but knew the LG was made informed that they would need to pick up the clients medications from the facility within a certain timeframe or the medications would be discarded; - FC #1 went to the hospital after having spit out his medications and having three meltdowns. She called the LG twice to discuss FC #1's behaviors and to get her (LG) input, however the decision was made to send him out to the hospital to assure the safety of himself and others. Interview on 1/9/19 with the facility's Vice President (VP) of Operations revealed: - Clients who were "sent out" to the hospital for behavioral issues were not considered discharged clients; - Clients who were considered "discharged clients" were clients who completed the program; - EMS transported clients to the hospital. Facility staff did not accompany clients to the hospital with EMS nor did they meet the ambulance or the LG at the hospital. Based on her prior experience working in a hospital setting EMS and/or the hospital staff were present to supervise clients at all times at the hospital, in that, they assumed custody; - Facility unable to provide documentation to	V 271			

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V 271	Continued From page 26 support clients supervision status while at the hospital; - Facility staff would call the hospital to report client information to the hospital's charge nurse, thereafter it became the LG's responsibility to get to the hospital to meet the client; - Facility called and made every attempt to reach the LG however acknowledged a client may have already left the facility with EMS and/or arrived at the hospital without the LG being made aware of the specifics; - Facility had not had any issues where a LG could not get to the hospital to meet a client, however acknowledged there was no communication with EMS or the hospital to confirm the arrival to the hospital or when/if the the LG arrived; - Facility had no policy/procedure/protocol for clients who were "sent out" to the hospital due to behaviors; - Facility did not send any documentation to assist EMS or the hospital to assure an appropriate plan of action was initiated nor did they follow up with the hospital after the client arrived; - Facility sent all clients medications and belongings with them while being transported by EMS in the ambulance because "we know it's hard for parents to get back to the facility." - Clients were required to go through the intake process again in order to be considered for re-admission. Interview on 1/19/19 with a Registered Nurse (RN) at the facility revealed: - Job duties included but were not limited to screening and assessments for placement, care coordination with the MD, the therapist, charting, crisis delegation; - FC #1 was a 6 year old male who had had behaviors all day long, staff processed and	V 271			

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V 271	Continued From page 27 engaged but he (FC #1) screamed from 8am-2:30pm. Change of shift between 2nd and 3rd during the evening around 7pm his behaviors escalated. FC #1's LG came to the facility and met with the DR same day he was sent out however after she arrived he calmed down. The nurse she relieved sent client #1 out because "she was not dealing with him with no back up additional staff and clients escalating behaviors." She (RN) suggested calling grandma/LG when he continued to verbally act out "amped up" but the nurse got approval to send client #1 out to the hospital. - Clients were not given IM medications at the facility. Normally clients who were sent out to the ED spoke to the psychiatrist to assess acute needs and the need for an increased level of care. She (RN) would call the LG, EMS and get LG to consent to transport over the phone, however sometimes could not get in touch with the LG. At the same time she would call 911 so they would not have to wait the LG had given the consent. Clients were able to come back to the facility, but the on call doctor rarely gave consent for them to return because they were not familiar with the clients and the night shift had limited resources and staff to support client's behaviors. Before anyone got hurt client's were sent out to the hospital "it's a safety concern." - The medications the facility administered did not work. Saphris was sublingual and took 1-2 hours to work, po (orally) medications had no results, no injections were given at all and there was no seclusion room. - The facility would send all client belongings and medications with the client when they were sent out, "techs" (technicians) gathered those items together. The clients always rode alone with EMS. Staff did not accompany the clients to the hospital or met the legal guardians at the hospital	V 271			

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V 271	Continued From page 28 or who followed up about the client after he/she was sent to the hospital therefore could not confirm if clients ever arrived to the hospital or if LG ever arrived to the hospital; - The facility did not have a follow up plan for clients after they left; - 9 out of 10 clients who were sent out to the hospital for behavioral issues did not return but could be re-admitted by going through the intake process again; - Clients sent out to the hospital had no paperwork sent with them however she (RN) recently developed a form with demographics and pertinent information after the issue was brought up as a concern. The form is included now with the admission packet "Emergency transfer form."; - "Food service should be last on the list and figure out what to do with the kids and their behaviors." Interviews on 1/10/19 and 1/14/19 with Hospital Administration Staff revealed: - Paperwork was not sent with the patients to ED "very infrequently" ER nurse had to consistently call the facility to get pertinent information about the client and most of the time no one answered or they received the voicemail. Unaware if medications or belongings were sent. Not always a crisis issue, per medic staffing was the major issue. The hospital SW had to determine who the clients LG was to discuss patient needs and at times the LG either arrived hours or days later or never arrived. They often had to rely on the minor patients to give them history and pertinent information including who their legal guardian was, which at times was impossible and unless the patients medications were documented in the system they had no idea what they were being administered because the facility did not send the medication information. The hospital was	V 271			

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V 271	Continued From page 29 "holding clients, social holds" and the ED always had a sitter at the hospital for clients while the SW tried to find the LG, and coordinate recommendations and placement; - FC #1 was transported to the hospital ED by ambulance; - Facility staff did not accompany FC #1 and/or meet the FC #1 and LG at the hospital; - Facility did not send any paperwork with client #1's pertinent information including medications and/or medication list and no belongings were sent with FC #1; - Hospital had a pre-arrival form available for completion prior to patient's arrival however the facility never contacted the hospital; - Hospital contacted the legal guardian and advised her to bring FC #1's medication list, in which she did; - Facility never called about FC #1 or followed up after he arrived to the hospital by ambulance; - FC #1 was sent with an incomplete medication list. Legal guardian provided the medication information to the ED; LG was not sure of the events that led FC #1 being sent to the hospital. "Extremely poor communication," the hospital was left with having to figure out FC #1's next plan of treatment; - FC #2's LG refused to pick FC #2 up from the hospital and wanted to relinquish his rights and the facility never called to follow up; - FC #3 was kept at the hospital for a month and the facility never called to follow up; - Communication with EMS reported the facility staff told them (EMS) the clients "can't come back" and the facility's issues were around lack of adequate staffing versus client behaviors, therefore the clients were "taking up room's just housing clients." - No communication from the facility; the facility never called the hospital to follow up, no one	V 271			

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V 271	Continued From page 30 answered the phone at times and only received voicemail therefore continued to call until a live person was reached which often never happened; - Clients were not always able to effectively communicate the information needed and attempts to get input from a client as young as six years old posed a challenge if not impossible; - The hospital had recently met with the facility to discuss all of these issues and concerns however the facility responded defensively and took no responsibility; - "[Facility] sent us another pt to ED yesterday (1/27/19) without calling report and told medic the pt was not welcome back. This time, they sent a brief form with contact info and meds listed, though ..." Interview on 1/14/19 with Emergency Medical Services (EMS) administration staff revealed: - The patients from this facility were always transported alone so without all pertinent information and staff support they assumed custody of the minor until they arrive to the hospital ED; - EMS expectations of a licensed facility was to receive and be provided full chart access with pertinent information about the clients' issues/concerns/medications and who the Power of Attorney (POA) was to receive proper consents to provide treatment and be able to communicate with the ED staff to help determine the most appropriate treatment options. This deficiency is cross referenced into 10A NCAC 27G .5001 Facility Based Crisis Scope (V269) for a Type A1 rule violation and must be corrected within 23 days.	V 271			