Division of Health Service Regulation

| 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 _____ | 02/20/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 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 |
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| V 000 | INITIAL COMMENTS<br><br>A complaint & follow up survey was completed on 2/20/19. The complaints were substantiated Intake #NC00148256; NC00148389; NC00146426; NC00147232; NC00147156; NC00146870 & NC00147040.<br><br>This facility is licensed in the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment Center for Children and Adolescents. | V 000 | *Begin V105*<br><br>*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.*<br><br>*Pursuant to your request, the corrective actions are delineated in the following pattern:*<br><br>*a) The procedure for preventing the deficiency and implementing the acceptable plan of correction for the specific deficiency identified;*<br>*b) The date by which all corrective actions will be completed, and the monitoring system will be in place.*<br>*c)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.*<br>*d)The title of the person responsible for implementing the acceptable plan of correction*<br><br>**A) The procedure for preventing the deficiency and implementing the acceptable plan of correction for the specific deficiency identified:**<br><br>An audit of all PRTFs Judicial Review documents will be completed by 3/29/19 by the Administrative Staff (AS) to ensure compliance. Any out of compliance areas will be remediated. Concurrent audits will be completed weekly by the AS to include a review of the dispositions with the court tracker and making any necessary updates to the court tracker.<br><br>The AS is now completing the following procedures/responsibilities:<br><br>-Preparing a daily list of all voluntary patients and sending the list of patients daily to the court and special counsel.<br><br>-Sending an updated list of admissions/discharged patients to the court and special counsel<br><br>. -Notifying the physicians of the daily admissions that require a Qualified Physical Examination (QPE). | B) 3/29/19 |
| V 105 | 27G .0201 (A) (1-7) Governing Body Policies<br><br>10A NCAC 27G .0201 GOVERNING BODY POLICIES<br>(a) The governing body responsible for each facility or service shall develop and implement written policies for the following:<br>(1) delegation of management authority for the operation of the facility and services;<br>(2) criteria for admission;<br>(3) criteria for discharge;<br>(4) admission assessments, including:<br>(A) who will perform the assessment; and<br>(B) time frames for completing assessment.<br>(5) client record management, including:<br>(A) persons authorized to document;<br>(B) transporting records;<br>(C) safeguard of records against loss, tampering, defacement or use by unauthorized persons;<br>(D) assurance of record accessibility to authorized users at all times; and<br>(E) assurance of confidentiality of records.<br>(6) screenings, which shall include:<br>(A) an assessment of the individual's presenting problem or need;<br>(B) an assessment of whether or not the facility can provide services to address the individual's needs; and | V 105 | | |

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rachel Beal — TITLE: CEO — (X6) DATE: 3/25/19

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| V 105 | Continued From page 1<br>(C) the disposition, including referrals and recommendations;<br>(7) quality assurance and quality improvement activities, including:<br>(A) composition and activities of a quality assurance and quality improvement committee;<br>(B) written quality assurance and quality improvement plan;<br>(C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services;<br>(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;<br>(E) strategies for improving client care;<br>(F) review of staff qualifications and a determination made to grant treatment/habilitation privileges:<br>(G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death;<br>(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; | V 105 | V105 Continued<br><br>-If the AS receives no acknowledgment from the physician or if the QPEs are not completed, the AS is attempting to contact the attending physician.<br><br>-If the attending physician cannot be contacted, the Medical Director is being notified immediately by the AS and made aware of the situation.<br><br>-The Medical Director is now instructed to and is following up with the physician or completing the QPEs.<br><br>- The AS is now placing the QPEs on the charts and if they're not completed within 24hrs. The AS gives the forms directly to the physicians.<br><br>The AS is now instructed to and will follow up by the end of the day or the next morning and remove completed QPEs from the charts.<br><br>-Copies are now being made by the AS and sent to the court.<br><br>-The court tracker is being updated daily by the AS with all new admissions and rehearing/dispositions.<br><br>-For concurrent QPEs, the therapist is now monitoring the court tracker and ensuring they complete QPEs that are due on their caseload.<br><br>The completed QPEs are being placed in the HIM box to be sent to the court. | |

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| V 105 | Continued From page 2<br><br>This Rule is not met as evidenced by:<br>Based on record review and interviews the facility failed to follow their policy to ensure Judicial Reviews were completed for five of seven audited clients (#004617, #004428, #005229, #004924, #005381). The findings are:<br><br>Review on 2/20/19 of Facility Policy "Judicial Review Upon Admission" dated 7/12/12 revealed:<br>-"A minor admitted to the 24 hour facility where the court has concurred with the placement has the right to a re-hearing for continued treatment after the initial 90 day authorized period...<br>-Subsequent re-hearings shall be scheduled at the end of each authorized period, but no longer than every 180 days.<br>-The Qualified Professional shall notify the clerk of court no later than 15 days before the end of the authorized admission.<br>-At this time the clerk of court will schedule a re-hearing prior to the last day of the authorized admission..."<br><br>A. Review on 2/19/19 of client #004617's record revealed:<br>-Admission date of 5/17/18<br>-Diagnoses of Oppositional Defiant Disorder (ODD), Attention Deficit Disorder with Hyperactivity (ADHD)and Post Traumatic Disorder (PTSD).<br><br>Further review of client record revealed:<br>-"Order for Voluntary Admission of Minor" dated 5/17/18, authorized for 90 days.<br>-No other request for hearings present in client's record. | V 105 | V105 Continued<br><br>***C) The monitoring procedure to ensure that the plan of correction is effective, and that specific deficiency cited remains corrected:***<br><br>To ensure compliance, 100% of the PRTF charts are being audited weekly by the AS for 3 months to ensure compliance. After 3 months, if results are at 98% or above, the percent of applicable charts reviewed will reduce to 50% but the sample will return to 100% if less than 98% until this result is again achieved. The AS and or designee is reporting any charts out of compliance and reason for same.<br><br>- A summary of the findings is being forwarded to the Morning meeting of Hospital Leadership Monday through Friday (with F, S, and S findings being reported into the Monday meeting), the monthly Quality/PI Council, the monthly Medical Executive Committee and the Governing Board at each of their respective meetings. The findings from the review will be continued at the Morning Meeting for a period of 3 months, and, if at 98% and above, the results will be reduced to a review at the monthly Quality/PI Council Meeting.<br><br>**D) Responsible person**:<br><br>Director of Compliance/Quality/Risk<br><br>V105 Ends | |

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| V 105 | Continued From page 3<br>B. Review on 2/19/19 of client #004428's record revealed:<br>-Admission date of 4/4/18.<br>-Major Depression Disorder, ODD and ADHD.<br><br>Further review of client record revealed:<br>-"Order for Voluntary Admission of Minor" dated 11/21/18, authorized for 23 days.<br>-No other request for hearings present in client's record.<br><br>C. Review on 2/19/19 of client #005381's record revealed:<br>-Admission date of 11/14/18.<br>-Diagnosis of Conduct Disorder.<br><br>Further review of client record revealed:<br>-"Order for Voluntary Admission of Minor" dated 11/29/18, authorized for 45 days.<br>-No other request for hearings present in clients record.<br><br>D. Review on 02/19/19 of client #005229 record revealed:<br>-Admission Date 10/17/18<br>-Diagnosis of Disruptive mood Dysregulation d/o, and ODD.<br><br>Further review of client record revealed:<br>-"Order for Voluntary Admission of Minor" dated 11/01/18 authorized for 50 days.<br>-No other request for hearings present in clients record.<br><br>E. Review on 02/19/19 of client #004924 record reveals | V 105 | | |

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| V 105 | Continued From page 4<br>-Admission date 08/17/18<br>-Diagnosis of Bipolar discord<br><br>Further review of client record revealed:<br>-"Order for Voluntary Admission of Minor" dated 10/25/18 authorized for 60 days.<br>-No other request for hearings present in clients record.<br><br>During interview on 2/20/19 the Special Counsel assigned to the clients stated:<br>-This has been an ongoing issue with clients not getting their hearings after the Order for Voluntary Admission authorization had expired.<br>-They have an employee assigned to this and he is doing the best he can, but there was a huge back log and he needs more training in handling this.<br>-These hearings should be scheduled two weeks prior to authorizations expirng and "this is not getting done."<br>-These clients have a right to a hearing and they are being denied that right.<br>-Had a long list of clients who had not had their hearings in months, the staff hired to do this is now working on it.<br>-Some clients had not had a hearing since their authorization since last summer.<br>-Had discussed this with several people in the facility, the CEO, Directors and whoever else would listen.<br><br>During interview on 2/20/19 the CEO stated:<br>-"I am very surprised to hear this."<br>-Things had been put in place months ago to clear this are of non compliance up.<br>-Will follow up and make sure these hearings are scheduled accordingly.<br>-No one had ever mentioned concerns from the Special Counsel Office to her regarding this | V 105 | | |

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| V 105 | Continued From page 5<br>issue. | V 105 | Begin V118<br>**A) The procedure for preventing the deficiency and implementing the acceptable plan of correction for the specific deficiency identified:**<br>All nursing staff with medication administration responsibilities are being re-educated on the process for overriding medication in the PXYIS system, as delineated in Pharmacy Policy 1700.39 and Pharmacy Policy. 1700.13 Override Policy.<br>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.<br>**B) 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:**<br>Daily, the Director of Nursing, or trained delegate, will review a 30% sample of all patient's records to ensure compliance with medication administration practices.<br>Nursing staff not meeting these requirements will be addressed on a progressive disciplinary basis.<br>These results are being aggregated and reported weekly to the Morning Meeting of Hospital Leadership. The findings, conclusions, recommendations, and actions taken, to the monthly Quality/PI Council, the monthly Medical Executive Committee and the quarterly Governing Board Committee meetings. This process will continue for 90 days. If results are at 95% compliance or above, the sample will reduce to 15% and the results will continue to be reported on a weekly basis to the GB appointee, to the monthly Quality/PI Council, the monthly Medical Executive Committee and the quarterly Governing Board Committee meetings. Any results below the standard of 95% will require that the specific indicator(s) be returned to a 30% review until the results are again at 95% for 30 consecutive days.<br>**D) The title of the person responsible for implementing the acceptable plan of correction:**<br>Director of Nursing<br>V118 Ends | b) 4/12/19 |
| V 118 | 27G .0209 (C) Medication Requirements<br><br>10A NCAC 27G .0209 MEDICATION REQUIREMENTS<br>(c) Medication administration:<br>(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.<br>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.<br>(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.<br>(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:<br>(A) client's name;<br>(B) name, strength, and quantity of the drug;<br>(C) instructions for administering the drug;<br>(D) date and time the drug is administered; and<br>(E) name or initials of person administering the drug.<br>(5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. | V 118 | | |

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| V 118 | Continued From page 6<br>This Rule is not met as evidenced by:<br>Based on record review and interview the facility failed to ensure 1 of 2 audited former clients (FC #004670) medications were administered on the written order of a physician. The findings are:<br><br>Record review on 2/19/19 of FC#004670 record revealed:<br>- admitted to the facility on 6/14/18 & discharged 1/16/19<br>- diagnoses of Unspecified Pervasive Development Disorder; Post Traumatic Stress Disorder and Unspecified Impulsive Disorder<br>- a physician's order dated 6/6/18: Vyvanse 30mg in the morning (used to treat attention deficit hyperactivity disorder (ADHD); 6/13/18: Differin .16% cream at bedtime (used to treat acne); 6/16/18: Amphetamine 10mg at 2pm and 12/18/18 (used to treat ADHD):<br><br>Review on 2/19/19 of the December 2018 & January 2019 MARs for RC#004670 revealed the following:<br>- the back of December's MAR: (12/30/18): Amphetamine "not provided - not available & (12/31/18) Vyvanse & Amphetamine "not available - ordered from the pharmacy"<br>- on the back of the January 2019 MAR: (1/1/19): Amphetamine "unavailable - ordered from the pharmacy; Vyvanse (unavailable) & Differin was "not available 1/4/19-1/10/19"<br><br>During interview on 2/20/19 the Chief Nursing Officer reported:<br>- the medications were available however it may have been in another pyxis machine<br>- contracted nurses may not have been aware to check a different pyxis machine for the medications<br>- medication training will be completed with | V 118 | | |

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| V 118 | Continued From page 7<br>contracted nurses and the facility's nurses this week | V 118 | Begin V367<br>**A)** The DQCR has been re-educated on requirements related to reporting Investigations and updates to the LME. It has been emphasized that this report must be within 72 as delineated in, G.S. 108A Article 6, G.S. 7B Article 3 and 10A NCAC 27G .0610. | **B)** on-going but training to be completed by 04/01/2019. |
| V 367 | 27G .0604 Incident Reporting Requirements<br><br>10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS<br>(a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:<br>(1) reporting provider contact and identification information;<br>(2) client identification information;<br>(3) type of incident;<br>(4) description of incident;<br>(5) status of the effort to determine the cause of the incident; and<br>(6) other individuals or authorities notified or responding.<br>(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:<br>(1) the provider has reason to believe that information provided in the report may be | V 367 | **C)** Compliance with the requirement to report to the LME within 72 hours are being monitored as follows:<br><br>1) The DQCR will present information on any investigation report that was completed within 72 hours to the LME, to the CEO on a M-F basis. The DQCR shall maintain documentation to this effect to be made available for the CEO to review per her request that the report to the LME has been made within 72 hours 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.<br><br>2) Evidence of the DQCR's compliance with reporting requirements will be reported weekly 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.<br><br>This process will continue as presented on a go-forward basis and has no end date.<br><br>**D)** The Director of Quality, Compliance, and Risk Management<br><br>V367 Ends | |

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| V 367 | Continued From page 8<br>erroneous, misleading or otherwise unreliable; or<br>(2) the provider obtains information required on the incident form thatwas previously unavailable.<br>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:<br>(1) hospital records including confidential information;<br>(2) reports by other authorities; and<br>(3) the provider's response to the incident.<br>(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).<br>(e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:<br>(1) medication errors that do not meet the definition of a level II or level III incident;<br>(2) restrictive interventions that do not meet the definition of a level II or level III incident;<br>(3) searches of a client or his living area;<br>(4) seizures of client property or property in the possession of a client;<br>(5) the total number of level II and level III incidents that occurred; and | V 367 | | |

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| V 367 | Continued From page 9<br>(6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interviews the facility failed to ensure: one of five audited former client's (FC #284302) investigation report was completed within 72 hours to the LME and two of five audited former clients (#413201 & # 454303) incident was investigated and reported to the LME within the 72 hours and one of five audited former clients (FC #04477) incident was thoroughly and comprehensively investigated with follow-up on preventative measures for the future. The findings are:<br><br>A. Review on 2/19/19 of FC #284302 revealed:<br>-Admission date of 5/3/18.<br>-Diagnoses of Disruptive Mood Dysregulation Disorder, Oppositional Defiant Disorder and Attention Deficit with Hyperactive Disorder.<br><br>Further record review on 2/20/19 of Incident Report dated 12/2/18 revealed:<br>-On 6/25/18, "The patient [FC# 284302] was in an agitated state. The nurse on duty was seated with him trying to de-escalate the situation. When the staff member walked into the room the patient became more agitated and spit on him. It is reported that the staff member hit the patient in the side of the head. The nurse ordered him off the hall and nurse management was called. The staff member was placed on | V 367 | | |

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

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| V 367 | Continued From page 10<br>administrative leave on 6/25/18 until the investigation was completed. He was terminated on 6/29/18. A report was filed with Department of Social Services on 12/11/18."<br><br>Review on 2/19/19 of "Investigation Reporting Form" completed 6/25/18 by Director of Quality, Compliance & Risk Management.<br><br>During interview on 2/19/19 the Director of Quality, Compliance & Risk Management stated:<br>-The incident with FC #284302 occurred on June 25.<br>-The incident was substantiated and the staff was terminated on 6/29/19 after an internal investigation.<br>-There was no Level II incident report completed and submitted to the LME regarding this incident until 12/11/18.<br>-There was a back log of incident reports that had not been completed and they had been getting them caught up.<br>-They had lots of meeting and strategies have been put in place to correct this going forward.<br><br>B. Review on 2/20/19 of "Investigation Reporting Form" dated 6/8/18 completed on 12/13/18 by Director of Quality, Compliance & Risk Management revealed:<br>-"I received a verbal complaint stating that a powdery substance was found in one of the classrooms. No incident report was received.<br>-The substance was not secured by the former Environment of Care (EOC) Director. The patients were not tested. The investigation was delayed because the proper processes were not followed for reporting the events.<br>-On 6/8/19..LPN (Licensed Practical Nurse) documented on [FC# 413201], able to make | V 367 | | |

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| V 367 | Continued From page 11<br>needs know, denies any pain or discomfort. No SI or HI thoughts. Patient licked a powdery substance in class today. Vitals taken, no distress noted. Patient took all meds well. Continue with Q15 vitals will monitor.<br>-On 6/8/18...LPN documented on [FC# 454303], patient c/o of hearing voices and being anxious. Patient also licked powdery substance while in class. No complaint of pain and discomfort, vitals were taken. PRN (as needed) meds given for anxiety, tolerated medications well. Close observation at all time."<br><br>During interview on 2/20/19 the Director of Quality, Compliance & Risk Management revealed:<br>-The incident with the white powder happened on a Friday back in the summer.<br>-Lots of things were going in the facility that day and "they dropped the ball."<br>-The EOC director came and told her about it and got statements.<br>-Did not follow policy on reporting/testing the powder.<br>-"Did not do an incident report, not follow up on it."<br>-The EOC director is no longer employed at the facility.<br>-When she realized the incident report had not been completed in December 2018.<br><br>C. The following is an example of the facility's failure to conduct a thorough comprehensive investigation with follow-up on preventative measures for the future<br><br>Review on 2/19/19 of FC #004477's record | V 367 | | |

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| V 367 | Continued From page 12<br>revealed:<br>-admitted 4/13/18<br>-diagnoses included diabetes, post-traumatic stress disorder and attention deficit hyperactivity disorder<br>-discharged 12/21/18<br><br>Review on 2/20/19 of the facility's policy and procedure manual revealed:<br>Medication Reconciliation<br>-At the time of discharge, the nurse will list the patient's current medication as noted on the physician's discharge orders on the Discharge Plan. The Discharge Plan is given to the guardian at discharge.<br>-The RN will educate the patient and family members about the importance of managing medication information.<br><br>Review on 2/20/19 of an IRIS report (Incident Response Improvement System)dated 1/30/19 involving FC #004477 revealed:<br>-FC #004477 was discharged with medication that didn't belong to her<br>-incident occurred at the time of FC #004477's discharge<br>-date of incident documented incorrectly as 12/20/18<br>-date Strategic Behavioral Center-Garner learned of incident 1/3/19<br>-cause of this incident section only restated the incident itself: "The patient was discharged with medication that didn't belong to her. It was determined that this wasn't a systemic issue. This was an isolated incident."<br>-incident prevention section documented the Chief Nursing Officer (CNO)reviewed FC #004477's chart and addressed the issue with the Registered Nurse House Supervisor(RN)who facilitated the discharge. The Medication | V 367 | | |

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| V 367 | Continued From page 13<br>Reconciliation policy wasn't adhered to and nursing re-education was provided by the CNO and the RN House Supervisor.<br>-no investigation information regarding any attempts made by Strategic Behavioral Health-Garner to find out from FC #004477's guardian or the other outside entities involved in her care post discharge which client's medications had been sent home in error and which if any of those had FC #004477 taken and what effect this had on FC #004477's health<br><br>Review on 2/20/19 of the facility's QSTATIM report (Quality stat Incident Manager)dated 1/30/19 involving FC #004477 revealed:<br>-event date 12/21/18 at 5:00pm<br>-discovered date 1/8/19 at 4:00pm<br>-entered date 1/30/19 at 9:35am<br>-medication error category selected was "An error occurred that may have contributed to or resulted in a temporary harm to the patient and required intervention"<br>-contributing factors category selected was "distraction"<br>-assessment narrative box "[CNO] reviewed the patient's medical chart. And it was determined that [the RN House Supervisor] failed to follow the Medication Reconciliation policy. As a result, the patient discharged with another peer's medication. [the RN House Supervisor] received reeducation/training from [CNO]. Mini RCA (root cause analysis) will be conducted within the next week."<br>-no investigation information regarding any attempts made by Strategic Behavioral Health-Garner to find out from FC #004477's guardian or the other outside entities involved in her care post discharge which client's medications had been sent home in error and which if any of those had FC #004477 taken and | V 367 | | |

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| V 367 | Continued From page 14<br>what effect this had on FC #004477's health<br><br>Interview on 2/20/19 with the CNO revealed:<br>-the RN House Supervisor was the staff's signature on the discharge papers for FC #004477<br>-she determined the "root cause" of the medication error was related to the RN House Supervisor was in a hurry during the discharge of FC #004477 along with lack of communication between the RN House Supervisor and LPN #1<br>-she had a discussion with the RN House Supervisor regarding the Medication Reconciliation Policy and safety issues related<br>-she discussed with the RN House Supervisor that adhering to this policy was not new to the RN House Supervisor as they had just reviewed this issue in a staff meeting<br>-retraining, since facility became aware of the discharge medication error, for staff involved Town Hall Meetings and Monthly Nursing Meetings<br>-they were busy the day FC #004477 was discharged<br>-LPN #1 told her she was the staff who pulled the medications<br>-LPN #1 told her she did not recall seeing another client's medications mixed in the bag with FC #004477's medications<br>-she did not know whether the RN House Supervisor or LPN #1 had been the staff who actually placed the medications in the bag at the time of FC #004477's discharge<br>-she did not know for sure which staff had actually reviewed the medications with FC #004477's guardian at the time of discharge<br>-as follow-up to the reeducation training of reviewing the Medication Reconciliation policy with the RN House Supervisor, she (CNO)asked the RN House Supervisor how things were going | V 367 | | |

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| V 367 | Continued From page 15<br>-the RN House Supervisor assured CNO that she checks all things now<br>-she has not conducted any further follow-up with observation, interview or documentation to review for compliance with the Medication Reconciliation policy and discharge process of the facility with the RN House Supervisor<br>-she did not know which other client's medication was sent home with FC #004477 at the time of her discharge<br>-no attempts made by Strategic Behavioral Health-Garner to find out from FC #004477's guardian or the other outside entities involved in her care post discharge which client's medications had been sent home in error and which if any of those had FC #004477 taken and what effect this had on FC #004477's health<br><br>Review on 2/20/19 of a facility Town Hall Meeting Agenda dated 1/29/19 and 1/30/19 revealed meetings were held at 5 different times between the 2 dates with the following outline:<br>-Joint Commission<br>-What is Joint Commission?<br>-Standard Focus on<br>-Policy, Practice, How well do you know your organization?<br>-What does this mean for you? How can I make a difference?<br>-Environment of Care<br>-Areas of Focus - Nursing<br>-Medication Discrepancy<br>-Medication Error Policy<br>-Medication Reconciliation<br>-Medication Administration Documentation<br>-Educating the staff<br>-Do you know the organization?<br>-Do you know the policy? / Is practice different? | V 367 | | |

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| V 367 | Continued From page 16<br><br>Titles of staff attending these Joint Commission Town Hall Meetings included: Call Center, MHT (Mental Health Technician), Data Manager, Maintenance Technician, Therapist, Teacher, Community Liaison, Lead Cook, Infection Control, Milieu Manager, Psychiatrist, Education Director, Recreational Therapist, Housekeeper, Cook, Environmental Service Technician, Financial Counselor, Receptionist, Certified Nursing Assistant, LPN, RN.<br><br>Review on 2/20/19 of a Monthly Nursing Meeting Agenda dated 2/18/19 at 7:30pm revealed:<br>-meeting facilitator listed as the CNO<br>-discharge process/orders/medication reconciliation at discharge as one of the listed topic areas<br>-two attached monthly staff meeting - sign in sheets dated 1/18/19 and 1/20/19<br>-the RN House Supervisor was not signed in on either dated sign in sheet | V 367 | | |

STRATEGIC
BEHAVIORAL HEALTH
RALEIGH
*Good People. Good Science. Good Outcomes.*

March 25, 2019

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
C/O Rhonda Smith
2718 Mail Service Center
Raleigh, NC 27699-2718

RE: POC Complaint & Follow up Survey completed February 20, 2019. Intake #NC00148256; NC00148389; NC00146426; NC00147232; NC00147156; NC00146870 & NC00147040

Dear Ms. Smith:

Enclosed you will find the plan of correction our organization is submitting relative to the complaint survey noted above. We would like to assure you that we are dedicated to providing quality care for patients and we appreciate the courtesy extended to us by your colleagues during this survey.

Respectfully,

Rachel Beal

Rachel Beal, CEO

Enc: Plan of Correction

qsj