STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20140057	A. BUILDING: _____ B. WING _____	03/20/2019

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STRATEGIC BEHAVIORAL CENTER	2050 MERCANTILE DRIVE LELAND, NC 28451

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V 000	INITIAL COMMENTS A complaint survey was completed on March 20, 2019. The complaints (NC00149276 and NC00149419) were unsubstantiated and complaints (NC00148841 and NC00149647) were substantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment Facility for Children and Adolescents.	V 000	*SBH - Wilmington takes these findings seriously and has implemented what we feel is an effective plan of action to address the identified deficiencies and monitor for compliance with actions taken. Pursuant to your request, the response is structured as follows:* *1)The plan for correcting the specific deficiency cited;* *2) The procedure for implementing the acceptable plan of correction for the specific deficiency cited;* *3) The title of the person responsible for implementing the acceptable plan of correction; and* *4) The monitoring procedure to ensure that the plan of correction (POC) is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements.*	
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall	V 110	**V110** **1. The plan for correcting the specific deficiency cited.** A root cause analysis was completed March 27, 2109 with Governing Board (GB) representative and staff involved. The actions were derived as follows: A. Re-educate all direct care staff on verbal de-escalation techniques and conduct demonstration and return demonstration of same as part of the training. B. Re-educate all direct care staff on Handle with Care (HWC) including increased emphasis on verbal-de-escalation techniques. C. Re-educate all direct care staff on internal incident reporting expectations D. Review and update, as needed, the Hospital's Clinical Supervision Policy **2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited.** A. All direct care staff will be re-educated by HWC trainers on de-escalation techniques. Staff will be required to perform return demonstration on techniques to fulfill competency requirements. — April 7, 2019 B. All direct care staff will be re-educated by HWC trainers on HWC, regardless of their current certification for same. — April 7, 2019 C. All direct care staff will be re-educated by the Director of Compliance/Quality/Risk or trained delegate what is defined as an incident and the — May 1, 2019 (V110 continued below)	

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V 110	Continued From page 1 develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on observations, record reviews, and interview, 1 of 5 paraprofessional staff (#1) failed to demonstrate knowledge, skills, and abilities required by the population served. The findings are: Review on 3/15/19 of staff #1's personnel file revealed: -Hire date was 2/13/17. -Position, Mental Health Technician (MHT). -Fingerprint card dated 2/8/17 documented staff #1 was 6'6" tall, and weighed 220 lbs. (pounds). Review on 3/12/19 of client #2's record revealed: -12 year old male admitted 9/24/18. -Diagnoses included post traumatic stress disorder (PTSD) unspecified; attention deficit hyperactive disorder (ADHD) combined type; oppositional defiant disorder (ODD), asthma, seasonal allergies, depression; child victim of physical abuse and neglect; rule out sexual abuse; reactive attachment disorder; disruptive mood dysregulation disorder; unspecified impulse control and conduct related disorder; borderline intellectual functioning with significant impairments in mathematics; and, autistic spectrum disorder. -9/25/18 Initial Psychiatric Evaluation documented client #2 weighed 94.5 lbs. and was 57 ½ inches tall.	V 110	(V110 continued from prior page) expectation to complete an occurrence report for unusual incidents outside of the patient's routine course of care. D. The Hospital's policy on the Supervision of Paraprofessionals will be reviewed by Hospital Leadership and will be updated, as necessary, to reflect the expectations related to the supervision of paraprofessionals. **3. The title of the person(s) responsible for implementing the acceptable plan of correction:** Director of Compliance/Quality/Risk **4. The monitoring procedure to ensure that the POC is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements.** Compliance with requirements is being monitored as follows: 1) 100% of all episodes of seclusion or restraint occur are being reviewed as part of this Safety Committee meeting by video monitoring review to ensure that verbal de-escalation techniques are being utilized and to assess for the compliance with the requirements of HWC. 2) 100% of incidents reported by the House Supervisors are being compared against incident reports received and are reviewed daily in the Hospital's Safety Meeting (with F, S, and S incidents reported into Monday's meeting) to ensure evidence of reporting of all incidents. Staff out of compliance with either of these requirements are being addressed through the progressive disciplinary process. The findings are being reported on a Monday through Friday basis to the morning meeting of Hospital Leadership until at 100% for 60 consecutive days as well as to the monthly Quality/PI Council, monthly he Medical Executive Meetings and the quarterly (V110 continued on next page)	April 30, 2019

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V 110	Continued From page 2 Review on 3/12/19 of client #2's x-ray dated 3/2/19 revealed: -"There is a buckle type fracture involving the distal radius with 17 degrees angulation and no displacement. The elbow and wrist joints are intact in alignment. -Conclusion: Acute appearing left forearm fracture as described." Review on 3/12/19 of Daily Assignment Sheets dated 2/26/19 and 2/27/19 revealed: -Documentation staff #1 worked the 2nd shift on 2/27/19 (Wednesday). -Staff #1 was not documented as working any shift on 2/26/19 (Tuesday). Review on 3/12/19 of staff #1's written statement dated 3/1/19 revealed: -"I was standing at the front door. [Client #2] continued to kick and punch door. He began to run to dayroom to dump cooler on ground. I began to walk and check. Before i could get into the dayroom I noticed the door was hard to open. I opend door to notice [client #2] was holding door with his arm, on the door with me pushing door open. His elbow hit the wall. He walks out dayroom holding elbow. I began to walk to room and ask if he was ok. He said he was ok just needed some ice. I got ice and as i arrived back to his room a staff [staff #5] was looking to see what had happened I began to apologize and letting him know how accident happen. He began to (illegible word) and soon be back in the hallway out of area." Review on 3/12/19 of the Compliance Investigation Report for event date 2/27/19 revealed: -Event Description: "... [client #2] stated during	V 110	(V110 continued from prior page) Governing Board meetings. If results in either of these indicators ever fall below 100% compliance, they will again return to a review at the Morning Meeting (M-F), as delineated until at 100% compliance for 30 consecutive days with reports to the additional Committees, as noted above (End of V110)	

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V 110	Continued From page 3 his family session with [Therapist] on Thursday afternoon, February 28, 2019 that 'he got hurt last night.' He presented his wrist and it was clear that it was swollen and he is struggling to maneuver it. He reported it happened last night after 300 came in from outside. He reported that his hand was slammed somehow by the front day room door. His report that [staff #1] was involved and that it was Intentional. He reported that he was going in the front day room angrily and trying to slam the door something happened after that with the staff person." Observations on 3/12/19 at 3:00 pm on the 300 Hall revealed the door to the Day Room was a 3 foot wooden door with a vertical clear glass panel near the handle that was approximately 30 inches tall by approximately 2 1/2 inches wide. Observations on 3/14/19 at 11:43 am revealed a green cast on client #2's left forearm. Interview on 3/14/16 client #2 stated: -He had been at the facility for about 6 months. -He had broken his arm on Wednesday, 2/27/19, between dinner and med (medication) pass. They ate dinner at 4:45 pm and took medications after 8 pm. -Staff #1 saw him (client #2) go into the Day Room. Client #2 had his hand on the door trying to close the door and Staff #1 tried to open the door. His (client #2's) arm "got caught." Client #2 had his hand on the door handle, and when Staff #1 opened the door it pushed him (client #2) "all the way back" and his elbow hit the wall. After this happened he ran to his room crying. Staff #1 said not to do this again, and if he did he would keep pushing his elbow back into the wall. -Staff had to unlock the Day Room door, but on this day the door was open.	V 110		

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V 110	Continued From page 4 -Client #2 had walked around Staff #1 to get into the room. It appeared to him that staff #1 had opened the door to go inside for some reason. He (client #2) went around Staff #1 and shut the door. Staff #1 did not seem mad; "he was smiling" during the incident. -He (client #2) may have been in the room about 1 minute. He and Staff #1 were looking at each other when Staff #1 opened the door. Staff #1 was not talking to him through the door. Staff #1 used "all of his force" to open the door. -No one else saw this happen other than Staff #1 and himself. -His arm started hurting immediately. Staff #1 did not check his arm. -Staff #5 was at his bedroom door doing "close obs (observation)" with his roommate. Staff #5 called the nurse on his walkie-talkie. The nurse came right away, checked his arm, got ice, and put it on his arm. -He also complained to the nurse and told her his arm hurt "really bad" during the med pass. He went up to where Staff #6 (Lead MHT) was doing the mouth checks. Staff #6 told the nurse and the nurse said for him to go lay back down and she had staff #5 get more ice for him. Interview on 3/13/19 staff #5 stated: -He was working when client #2 hurt his arm. The clients had finished with recreation therapy around 7 pm and were told to leave the Day Room and return to their bedrooms. Client #2 went to his room initially, but then ran out of his room and was walking up and down the hall. Staff #1 opened the Day Room door to get some water for another client when client #2 tried to enter, but Staff #1 blocked him. Client #2 stayed in the hallway, going room to room, and another client asked for a cup of water. Client #2 tried to enter the Day Room again, and Staff #1 went to "block	V 110		

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V 110	Continued From page 5 him" and that is when client #2 said he was hurt. When Staff #1 opened the door, client #2 tried to go under Staff #1's arm and was blocked by Staff #1. He never saw client #2 go into the Day Room. Client #2's arm hit the door frame, he fell to the floor, and ran back to his room. After getting to his room client #2 said his arm was hurt once he laid on his bed. -Staff #5 called the nurse and reported the client was complaining of pain in his arm. The nurse put ice on client #2's arm right before the med pass. -He could not recall the exact day this happened, but thought it was on a Wednesday. Telephone interview on 3/14/19 the Registered Nurse stated: -She worked 12 hour shifts from 7 pm - 7 am on Wednesdays, Thursdays, and Fridays. -She was not made aware client #2 had injured his arm. Client #2 was crying and complaining of pain in his arm, going up and down the hall, and told her his arm was hurting. Due to his "out of control behavior," she sent him back to his room and checked on him after she passed out the night medications. He was in his room and not showing any signs of pain when she went to his room to check on him. It was not out of the ordinary for clients to complain of pain. These clients often had psychosomatic complaints. Client #2 did not tell her that he had hurt his arm earlier that day. None of the staff told her of an injury. At the start of her shift she had seen client #2 "running around... jumping around" and not showing any signs of pain. When she went to his room he said he was fine. She looked at his arm and there was no bruising or swelling. -She did not apply ice to his arm. She is not aware of anyone else putting ice on his arm.	V 110		

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V 110	Continued From page 6 Interview on 3/13/19 staff #1 stated: -His regular schedule was day shift, 7 am - 3 pm, Friday through Monday. He also worked extra shifts as needed. -He had "picked up" an extra shift, 2nd shift from 3 pm -11 pm, when client #2 injured his arm. He thought this was on a Thursday. Client #2 was on the hall and kicking the door that lead off the hall prior to the incident. The clients were supposed to be in their rooms at that time. He (staff #1) and staff #5 were positioned at the door when client #2 ran toward the door to kick it. Staff #1 extended his arm to give space between himself and the client. All of the other "kids" were in their rooms when client #2 ran into the Day Room, and no one else was in the dayroom at this time. Client #2 went inside the Day Room and was holding the door and Staff #1 was outside in the hallway. At first client #2 was holding the door with his foot, and on staff #1's first attempt to open the door it "popped back to me." Staff #1 then tried to open the door a 2nd time immediately after the first attempt, and pushed the door open. Client #2 had his arm on the door and when he opened the door his arm was pushed against the wood block on the wall behind the door. After this happened client #2 went to his room and staff #1 followed. Client #2 was lying face down on his bed, holding his arm. He asked the client if he was ok. After client #2 left the Day Room he was cursing loudly and the nurse came onto the hall. The nurse asked what was going on and client #2 said he wanted his snack and he mentioned his arm. The nurse did not go to his room and check him. -Maybe 15 to 20 minutes later staff #1 made rounds and client #2 said to staff #1 to look at his arm. Staff #1 looked and the arm client #2 was complaining about "looked different than his other arm ...it was not the same size." That was when	V 110		

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V 110	Continued From page 7 he went and got some ice in a zip lock bag and put it on the client #2's arm. -Staff #1 did not report to the nurse that he put ice on client #2's arm. -Staff #1 did not have to push hard to open the door. "[Client #2] is very small." He did not see client #2 behind the door. -Staff #1 thought this incident happened after dinner. Client #2 was on the 300 Hall and they go to dinner at 4:45 pm. After dinner the clients have "free time." -The next day after the incident, staff #1 was called and "put off" from work for 2 days for the investigation. He was called back to work the following Sunday. Interview on 3/12/19 the Director for Quality and Risk Management stated: -She had completed an investigation of the incident where client #2 fractured his arm and alleged staff #1 had done this intentionally. -According to her investigation, staff #1 looked in the window panel and did not see client #2 standing behind the door. -Staff #1 reported, when he opened the door, client #2's arm was caught between the wall and door. -There was video surveillance that recorded the door from inside the Day Room. Video had been reviewed from 5 pm - 7 pm for 2/25/19 - 3/1/19 and there was no evidence of staff #1 injuring client #2 with the door. -A short segment of video recording on 2/27/19 around 6 pm could not be retrieved for some unknown reason. The facility had no way to alter the tapes. This deficiency is cross referenced into 10A NCAC 27G .1901 Scope (V314) for a Type A1 and must be corrected within 23 days.	V 110		

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V 314	27G .1901 Psych Res. Tx. Facility- Scope 10A NCAC 27G .1901 SCOPE (a) The rules in this Section apply to psychiatric residential treatment facilities (PRTF)s. (b) A PRTF is one that provides care for children or adolescents who have mental illness or substance abuse/dependency in a non-acute inpatient setting. (c) The PRTF shall provide a structured living environment for children or adolescents who do not meet criteria for acute inpatient care, but do require supervision and specialized interventions on a 24-hour basis. (d) Therapeutic interventions shall address functional deficits associated with the child or adolescent's diagnosis and include psychiatric treatment and specialized substance abuse and mental health therapeutic care. These therapeutic interventions and services shall be designed to address the treatment needs necessaryto facilitate a move to a less intensive community setting. (e) The PRTF shall serve children or adolescents for whom removal from home or a community-based residential setting is essential to facilitate treatment. (f) The PRTF shall coordinate with other individuals and agencies within the child or adolescent's catchment area. (g) The PRTF shall be accredited through one of the following; Joint Commission on Accreditation of Healthcare Organizations; the Commission on Accreditation of Rehabilitation Facilities; the Council on. Accreditation or other national accrediting bodies as set forth in the Division of Medical Assistance Clinical Policy Number 8D-1, Psychiatric Residential Treatment Facility, including subsequent amendments and editions. A copy of Clinical Policy Number 8D-1 is available	V 314	V314 **1. The plan for correcting the specific deficiency cited.** A root cause analysis was completed March 27, 2019 with Governing Board (GB) representative and staff involved. A Plan of Action was, subsequently, developed as follows: A. Re-educate all direct care staff on verbal de-escalation techniques and conduct demonstration and return demonstration of same as part of the training. B. Re-educate all direct care staff on Handle with Care (HWC) including increased emphasis on verbal-de-escalation techniques. C. Re-educate all direct care staff on internal incident reporting expectations D. Review and update, as needed, the Hospital's Clinical Supervision Policy E Re-educate nurses that must document a Nursing Note per shift G. Director of Quality, Compliance, and Risk (DQCR) and Assistant will attend DHHS Mental Health Licensure Provider Training on June 10, 2019 for re-education on provider requirements. H. DQCR and assistant have been re-educated on the requirement to submit all level II or level III incidents into IRIS per requirements. **2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited.** A. All direct care staff will be re-educated by HWC trainers on de-escalation techniques. Staff will be required to perform return demonstration on techniques to fulfill competency requirements. — April 7, 2019 B. All direct care staff will be re-educated by HWC trainers on HWC, regardless of their current certification for same. — April 7, 2019 C. All direct care staff will be re-educated by the Director of Compliance/Quality/Risk or trained delegate what is defined as an incident and the expectation for the completion and submission of incident reports. — May 1, 2019 D. The Director of Compliance/Quality/Risk will coordinate the review by Hospital Leadership on the Hospital's Clinical Supervision Policy and revision of content, as is necessary. — April 30, 2019 (V314 continued on next page)	

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V 314	Continued From page 9 at no cost from the Division of Medical Assistance website at http://www.dhhs.state.nc.us/dma/. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure services were designed to provide therapeutic interventions to address functional deficits associated with the child or adolescent's diagnosis affecting 2 of 7 audited clients (#2, #3). The findings are: Cross Reference: 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (Tag V110). Based on observations, record reviews, and interview, 1 of 5 paraprofessional staff (#1) failed to demonstrate knowledge, skills, and abilities required by the population served. Cross Reference: 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (Tag V366). Based on record reviews and interviews the facility failed to implement policies for response to incidents as required. Cross Reference: 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (Tag V367). Based on record reviews and interviews, the facility failed to report all level II and level III incidents to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the	V 314	(V314 continued from prior page) E. All nurses will be re-educated by the Director of Nursing on the requirement that a Nursing Note be completed each shift. May 1, 2019 F. DQCR and assistant will attend DHHS Division of Mental Health Licensure Provider training. June 10, 2019 G.DQCR and Assistant have been re-educated on the requirement that all level II and level III incidents will be entered into IRIS within 72 hours. March 29, 2019 **3. The title of the person(s) responsible for implementing the acceptable plan of correction:** Director of Quality, Compliance, and Risk Director of Nursing **4. The monitoring procedure to ensure that the POC is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements.** Compliance with the corrective actions is being monitored as follows: 1)100% of all episodes of seclusion or restraint occur are being reviewed as part of this Safety Committee meeting by video monitoring review to ensure that verbal de-escalation techniques are being utilized and to assess for the compliance with the requirements of HWC. 2) 100% of incidents reported by the House Supervisors are being compared against incident reports received and are reviewed daily in the Hospital's Safety Meeting (with F, S, and S incidents reported into Monday's meeting) to ensure evidence of reporting of all incidents. Staff out of compliance with either of these requirements are being addressed through the progressive disciplinary process. 3) On a Monday through Friday basis (with reports from Friday, Saturday, and Sunday incorporated into Monday' report), the CEO or trained designee will compare 100% of level II and level III incidents against IRIS reports submitted to ensure all incidents have been submitted as required. (V314 continued on next page)	

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V 314	Continued From page 10 incident. Cross Reference: 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (Tag V500). Based on record reviews and interviews, the facility failed to notify the County Department of Social Services (DSS) of an allegation of abuse. Reviews of client #2's record on 3/12/19 revealed: -There were no nursing notes dated 2/27/19. -On 3/1/19 at 4:45 pm was client #2's first examination by the Physician Assistant (PA) for his complaint of arm pain following his injury on the evening shift, 2/27/19. PA documented client #2 was having pain in his left forearm s/p (status post) hitting it on a wall. Client complained of "throbbing/aching" pain that was worse with pronation/supination of the left wrist. Swelling was present to the distal forearm with redness. X-ray of left forearm ordered to rule out fracture. -On 3/2/19 at 10:34 am an x-ray was done and read by radiologist. Client #2 had a buckle type fracture involving the distal radius. Appeared to be an acute forearm fracture. -On 3/2/19 at 6:10 pm client #2 was seen. PA documented client #2 was having sharp pain, pain score of 8 out of 10; pain is worse with movement. "Send to the ER (emergency room) for splinting as ortho (orthopedic physician) is unavailable at this time... F/U (follow up) w/ (with) ortho on Monday." -On 3/2/19 at 6:10 pm client #2 was seen in the ER and returned to the facility at 11:55 pm with a splint on his left arm and a shoulder immobilizer to that side. Discharge instructions were given to follow up with an orthopedic surgeon as soon as possible. Review on 3/12/19 of the Therapist's e-mail dated	V 314	**(V314 continued from prior page)** 4) 30% of PRTF nursing notes will be audited weekly by the DON or designee to ensure compliance with completion per shift. When 100% compliance has been achieved for 30 consecutive days, the percentage of audited notes will reduce to 15% weekly. If at any time, compliance drops below 100%, compliance, the percentage of audits will increase back to 30% until at 100% for 30 consecutive days. The findings of the above indicators are being reported on a Monday through Friday basis to the morning meeting of Hospital Leadership until at 100% for 60 consecutive days as well as to the monthly Quality/PI Council, monthly Medical Executive Meetings and the quarterly Governing Board meetings. . If results in any of these indicators ever fall below 100% compliance, they will again return to a review at the Morning Meeting (M-F), as delineated until at 100% compliance for 30 consecutive days with reports to the additional Committees, as noted above. **(end of V314)**	

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V 314	Continued From page 11 2/28/19 revealed: -E-mail was sent at 4:17 pm and the recipients included the Director for Quality and Risk Management. -Client #2 had disclosed in family therapy that his arm had been hurt the prior night. His arm was clearly swollen and he was struggling to move it. He reported his arm had been "slammed" in the Day Room door intentionally by staff #1. -She questioned if camera footage could be viewed and wrote the client's mother wanted a follow up, as would the client's social worker when informed by the mother. Review on 3/12/19 of the facility Patient Advocate's e-mail dated 2/28/19 revealed: -E-mail was sent at 6:05 pm and the recipients included the Director for Quality and Risk Management. -She had interviewed client #2 about the incident with his arm. -She asked the nurse on duty to place an Internal Medicine consult to have the client seen. -The nurse on duty had not received any report of an injury to client #2's arm when she had taken report that morning, so was surprised to hear about the injury late in the afternoon from the therapist. Interview on 3/12/19 the Director for Quality and Risk Management stated: -Client #2 was sent to the ER on 3/2/19 and returned to the facility with a sling and splint. -Client #2 was seen by an orthopedic surgeon on 3/8/19 and the physician applied a cast to the client's left arm. Review on 3/15/19 of the Plan of Protection dated 3/15/19 and completed by the Director of Quality Compliance and Risk Management revealed:	V 314		

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V 314	Continued From page 12 -"What immediate action will the facility take to ensure the safety of the consumers in your care? Corrective Actions and Steps: All direct care staff will be retrained on GEARS (de-escalation techniques) and HWC (Handle With Care) to ensure patient safety at all times. Incident reports and requirements will be viewed with all staff beginning immediately at each shift. The Risk Manager and RM [Risk Manager]Assistant will ensure both IRIS, State, and Federal guidelines are always referenced for all incidents to ensure proper reporting. -Describe your plans to ensure the above happens. Responsible Party for corrections and monitoring for effectiveness of same: Program Coordinator/Supervisor, Milieu Manager, Risk Manager." Client #2 was a 12 year old male who weighed less than 100 lbs and was less than 5 feet tall. On a Wednesday evening, 2/27/19, client #2 was able to get into the Day Room on his unit and close the door. Staff #1, standing 6'6" tall, tried to open the door but client #2 had his foot against the door. Immediately staff #1 tried again, this time opening the door with enough force to push client #2's arm against the wall behind the door. Client #2 stated he felt pain in his arm immediately and reported his arm hurt to staff #1 and several other staff that evening. Staff #1 did not document/submit an Incident Report on 2/27/19. The nurse on duty the following day and the Director for Quality and Risk Management were made aware of the 2/27/19 incident around 4 pm on 2/28/19 after client #2 told his therapist staff #2 had intentionally hurt his arm. A medical consult was requested and client #2 was seen by the PA on 3/1/19 at 4:45 pm; had an x-ray on 3/2/19 at 10:34 am that identified a buckle fracture of his left arm. Client #2 was seen later	V 314		

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V 314	Continued From page 13 that day at 6:10 pm by the PA, who then referred him to the ER where his arm was stabilized. Staff #1's lack of knowledge and skill to intervene during non-compliant behaviors resulted in client #2 sustaining a fractured arm. The failure to submit an internal Incident Report delayed client #2's diagnosis and treatment/stabilization of his fractured arm by approximately 24 hours. The MCO (Managed Care Organization) was not notified of client #2's injury and allegation against Staff #1 until 3/4/19, and the facility never notified the County Department of Social Services of the allegation. Client #3 was an 11 year old male with a Major Depressive Disorder diagnosis (severe) and a history of suicidal ideation. On a Monday evening, 2/25/19, Client #3 was found unconscious on his bedroom floor. A T-shirt had been ripped into strips and tied around his neck. Smelling salts were utilized to assist client #3 with regaining consciousness and RN assessed client #3 for further injury. No additional injuries were noted and client #3 was moved from close observation to a 1:1 staffing ratio at 8:40pm by the physician on call. The facility never reported the suicide attempt by client #3 to the MCO. External reporting procedures by the facility to the MCO and County DSS prevented or delayed the review by outside entities responsible for oversight of the quality and safety of services. This deficiency constitutes a Type A1 rule violation for serious harm and must be corrected within 23 days. An Administrative Penalty of $3000 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 314		

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V 366	Continued From page 14	V 366	V366	
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond	V 366	**1. The plan for correcting the specific deficiency cited.** A. All direct care staff will be re-trained on the internal incident reporting expectations B. DQCR and Assistant will attend DHHS Division of Mental Health Licensure Provider training **2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited.** A. All direct care staff will be re-educated by the Director of Compliance/Quality/Risk or trained delegate what is defined as an incident and the expectation for the completion and submission of incident reports B. DQCR and Assistant will attend DHHS Division of Mental Health Licensure Provider training **3. The title of the person(s) responsible for implementing the acceptable plan of correction:** Director of Quality, Compliance, and Risk **4. The monitoring procedure to ensure that the POC is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements.** 100% of incidents reported by the House Supervisors are being compared against incident reports received and are reviewed daily in the Hospital's Safety Meeting (with F, S, and S incidents reported into Monday's meeting) to ensure evidence of reporting of all incidents. Staff out of compliance with these requirements are being addressed through the progressive disciplinary process. The findings are being reported on a Monday through Friday basis to the morning meeting of Hospital Leadership until at 100% for 60 consecutive days as well as to the monthly Quality/PI Council, monthly he Medical Executive Meetings and the quarterly	May 1, 2019 June 10, 2019

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V 366	Continued From page 15 by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not	V 366		

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V 366	Continued From page 16 available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to implement policies for response to incidents as required. The findings are: Review on 3/15/19 of the Incident Reporting Policy dated 5/24/16 revealed: -"Employees who witness or are aware of an incident are responsible for completing an Incident Report at the time they become aware of the incident or as soon as the situation is under control." -"An Incident Report must be completed anytime there is a potential injury (regardless of severity) to residents, employees, or visitors."	V 366		

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V 366	Continued From page 17 Review on 3/12/19 of client #2's record revealed: -12 year old male admitted 9/24/18. -Diagnoses included post traumatic stress disorder (PTSD) unspecified; attention deficit hyperactive disorder (ADHD) combined type; oppositional defiant disorder (ODD), asthma, seasonal allergies, depression; child victim of physical abuse and neglect; rule out sexual abuse; reactive attachment disorder; disruptive mood Dysregulation disorder; unspecified impulse control and conduct related disorder; borderline intellectual functioning with significant impairments in mathematics; and, autistic spectrum disorder. -Report of X-ray completed 3/2/19 revealed client #2 had a buckle type fracture involving his distal radius with 17 degrees angulation and no displacement. "Conclusion: Acute appearing left forearm fracture as described." Review on 3/12/19 of facility incident reports revealed: -There was no facility Incident Report documented by staff on 2/27/19 of client #2's injury. -Compliance Investigation Report for event date 2/27/19 documented: -"Findings: ... It is determined that the allegation against [Staff #1] is unsubstantiated. There is no evidence of [Staff #1] slamming the door into [client #2]. It is felt that if the injury was caused by pushing the door open, it was not intentional. It is still questionable if this was the actual event that [client #2] is referring to as he told several different dates and conflicting details to staff. Video review of last week (2/25 - 3/1/19 does not show any harm inflicted onto [client #2] by staff." -"Corrective Actions, Including HR (Human Resources): None."	V 366		

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V 366	Continued From page 18 Interview on 3/13/19 staff #1 stated: -He had "picked up" an extra shift, 2nd shift from 3 pm -11 pm, when client #2 injured his arm. He thought this was on a Thursday. -Client #2 was inside the Day Room and holding the door and staff #1 was outside in the hallway. Client #2 had his arm on the door and when staff #1 opened the door his arm was pushed against the wood block on the wall behind the door. After this happened client #2 went to his room and staff #1 followed. Client #2 was lying face down on his bed, holding his arm. -Maybe 15 to 20 minutes later staff #1 made rounds and client #2 asked staff #1 to look at his arm. Staff #1 looked and the arm client #2 was complaining about looked different than his other arm; it was not the same size. That was when he went and got some ice in a zip lock bag and put it on the client's arm. He did not tell the nurse he had put ice on the client's arm. Telephone interview on 3/14/19 the Registered Nurse stated: -She worked 12 hour shifts from 7 pm - 7 am on Wednesdays, Thursdays, and Fridays. -Client #2 was crying and complaining of pain in his arm, going up and down the hall, and told her his arm was hurting when she was passing medications. -None of the staff told her of an injury. -After she finished passing the night medications she went to see client #2 in his room. He said he was fine. She looked at his arm and there was no bruising or swelling. -She did not apply ice to his arm. She was not aware of anyone else putting ice on his arm. Interview on 3/12/19 a Detective with the county sheriff's office stated:	V 366		

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V 366	Continued From page 19 -The facility had been served with a search warrant the prior week for video surveillance tape of an incident between staff #1 and client #2. -The facility had provided video tape recordings in 2 hour segments from 5 pm - 7 pm from 2/25/19 - 2/28/19. -There was a "gap" of video recording on 2/27/19 from 6:03 pm - 6:10 pm. -Today the Risk Management Assistant had provided a flash drive with video recording for 2/26/19 from 3:45 pm - 8:25 pm. Refer to V110 for additional information. Interviews on 3/12/19 and 3/15/19 the Director for Quality and Risk Management stated: -She was responsible for the incident reporting process. -There were Incident Report forms available to any staff. -All staff were responsible for completing an Incident Report any time they become aware of an incident. -It had been difficult to determine the date client #2 fractured his arm. -No staff had documented an Incident Report for client #2's injury. -Not having an Incident Report submitted on 2/27/19 did delay the client being seen for his injury. -Video tapes had been viewed and they had not found any recording of client #2 being behind the door and injuring his arm injured as it was opened by staff #1. -There was a short segment of time around 6 pm on 2/27/19 that the video did not record for an unknown reason. -She could not locate the nurses notes dated 2/27/19.	V 366		

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V 366	Continued From page 20 This deficiency is cross referenced into 10A NCAC 27G .1901 Scope (V314) for a Type A1 and must be corrected within 23 days.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (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: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (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: (1) the provider has reason to believe that	V 367	V367 **1. The plan for correcting the specific deficiency cited.** A. Director of Quality, Compliance, and Risk (DQCR) and Assistant will attend DHHS Division of Mental Health Licensure Provider training B. DQCR and assistant have been re-educated on the requirement to submit all level II or level III incidents into IRIS per requirements. **2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited.** A. Director of Quality, Compliance, and Risk (DQCR) and Assistant will attend DHHS Division of Mental Health Licensure Provider training. B. DQCR and assistant have been re-educated on the requirement to submit all level II or level III incidents into IRIS per requirements. **3. The title of the person(s) responsible for implementing the acceptable plan of correction:** CEO **4. The monitoring procedure to ensure that the POC is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements.** On a Monday through Friday basis (with reports from Friday, Saturday, and Sunday incorporated into Monday' report), the CEO or trained designee will compare 100% of level II and level III incidents against IRIS reports submitted to ensure all incidents have been submitted as required. The findings of the above indicators are being reported on a Monday through Friday basis to the morning meeting of Hospital Leadership until at 100% for 60 consecutive days as well as to the monthly Quality/PI Council, monthly Medical Executive Meetings and the quarterly Governing Board meetings. (V367 Continued below)	June 10, 2019 March 29, 2019

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V 367	Continued From page 21 information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form thatwas previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III	V 367	(V367 cont) If results in any of these indicators ever fall below 100% compliance, they will again return to a review at the Morning Meeting (M-F), as delineated until at 100% compliance for 30 consecutive days with reports to the additional Committees, as noted above. This is an ongoing process and has no end date.	

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V 367	Continued From page 22 incidents that occurred; and (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. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report all level II and level III incidents to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The findings are: Finding #1: Review on 3/12/19 of the North Carolina Incident Response Improvement System (IRIS) revealed a level III incident report for client #2's injury and allegation of abuse against staff #1 originally submitted 3/4/19. Review on 3/12/19 of facility incident reports revealed: -There was no facility Incident Report documented by staff on 2/27/19 of client #2's injury. -Compliance Investigation Report for event date 2/27/19 documented: -"Event Description: ... [client #2] stated during his family session with [Therapist] on Thursday afternoon, February 28, 2019 that "he got hurt last night." He presented his wrist and it was clear that it was swollen and he is struggling to maneuver it. He reported it happened last night after 300 came in from outside. He reported that	V 367		

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V 367	Continued From page 23 his hand was slammed somehow by the front day room door. His report that [Staff #1] was involved and that it was Intentional." -"Findings: ... It is determined that the allegation against [staff #1] is unsubstantiated. There is no evidence of [staff #1] slamming the door into [client #2]. It is felt that if the injury was caused by pushing the door open, it was not intentional. It is still questionable if this was the actual event that [client #2] is referring to as he told several different dates and conflicting details to staff. Video review of last week (2/25 - 3/1/19 does not show any harm inflicted onto [client #2] by staff." -"Corrective Actions, Including HR (Human Resources): None." Interview on 3/13/19 the Therapist stated: -She had family session with client #2 and his mother via telephone on 2/28/19. They were talking about different therapeutic topics when client #2 said "I got hurt last night." She had client #2 to explain and he said it was "on purpose." Client #2 stated staff #2 told him he (staff #1) had done this "on purpose." -She asked client #2 to show her his arms, first prone position; she could not see anything. He turned his arms over and she could see one arm was visibly puffy. -She physically walked him back onto his unit where she talked with the Patient Advocate and informed the nurse that his arm was hurt. -She went back to her office and sent the email dated 2/28/19. Interview on 3/13/19 the facility Patient Advocate stated: -She talked with client #2 on the day she was informed by the therapist of his complaints. This was about 4:30 pm on that day.	V 367		

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V 367	Continued From page 24 -Client #2 said staff #2 closed the door on client #2's arm. He said he (client #2) was upset the night before, wanted to take time away, there were other clients bothering him, and he was trying to enter the day room and keep the others out. Staff #1 pushed the door open. The client was not clear to her how this happened, if he closed the door on his arm, or how else it happened. According to client #2 he had received a phone call that upset him and he went to day room to have away time. His arm was hurt, and the next day he was reporting. If she talked with him on 2/28/19 this would mean he was hurt 2/27/19. -Client #2 was holding his arm and trying to be gentle with it. -The lower part of his arm "looked puffy." -The nurse on duty looked at his arm and stated she would put in a medical consult to have him be seen. Refer to V110 for additional information. Finding #2: Review on 3/12/19 of the North Carolina Incident Response Improvement System (IRIS) revealed no level II incident reported for client #3's suicide attempt on 2/25/19. Review on 3/12/19 of facility incident reports revealed: -Health Incident Review Report completed on 2/25/19 by Licensed Practical Nurse (LPN) -Client #3 was found "unconscious on his room floor with torn strips of a T-shirt tied around his neck. RN (Nurse) was called - used smelling salt and resident regained consciousness immediately." -Incident identified as "suicide attempt." -Physician, Registered Nurse, DIrector for Quality	V 367		

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V 367	Continued From page 25 and Risk Management, and guardian (3 attempts) were notified. -Client #3 placed on 1:1 supervision. Review on 3/12/19 of Physician Note dated 2/26/19 revealed: -Client #3 placed on 1:1 for safety. Review on 3/12/19 of resident observation sheet dated 2/25/19 revealed: -Client #3 "monitored to ensure safety and compliance." -Client #3 "Displays self-injurious behaviors. " Interview on 3/15/19 the Director for Quality and Risk Management stated: -They follow the IRIS system chart to determine if an incident is Level I, II, or III. -She was responsible for reporting to IRIS and to other required outside entities. -She was waiting to complete the IRIS report for client #2's incident and allegation pending his x-ray results. This caused a reporting delay. -She could not recall the details pertaining to client #3. This deficiency is cross referenced into 10A NCAC 27G .1901 Scope (V314) for a Type A1 and must be corrected within 23 days.	V 367		
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and	V 500	V500 begins on next page	

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V 500	Continued From page 26 implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications. (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify: (1) the permitted restrictive interventions or allowed restrictions; (2) the individual responsible for informing the client; and (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who	V 500	V500 **1. The plan for correcting the specific deficiency cited.** A. DQCR and Assistant have been re-educated by DHHS/DHSR on the requirement that all accusations of abuse will be reported to the County Department of Social Services (DSS). B. DQCR and Assistant will attend DHHS Division of Mental Health Licensure Provider training. **2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited.** A. The DQCR and the Assistant have been re-educated on the requirement to report all allegations of abuse to the County DSS within the required timeframe. B. DQCR and Assistant will attend DHHS Division of Mental Health Licensure Provider training **3. The title of the person(s) responsible for implementing the acceptable plan of correction:** CEO **4. The monitoring procedure to ensure that the POC is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements.** 100% of allegations of abuse will be reviewed daily by the CEO or trained delegate and reviewed in the Hospital's Safety Meeting (with F, S, and S allegations reported into Monday's meeting) to ensure there is a corresponding DSS report. This is an ongoing process and has no end date.	March 29, 2019 June 10, 2019

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V 500	Continued From page 27 has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify the County Department of Social Services (DSS) of an allegation of abuse. The findings are: Review on 3/12/19 of client #2's record revealed: -12 year old male admitted 9/24/18. -Report of X-ray completed 3/2/19 revealed an acute appearing left forearm fracture. Review on 3/12/19 of Compliance Investigation Report for event date 2/27/19 revealed: -"Event Description: ... [client #2] stated during his family session with [Therapist] on Thursday afternoon, February 28, 2019 that "he got hurt last night." He presented his wrist and it was clear that it was swollen and he is struggling to maneuver it. He reported it happened last night after 300 (hall) came in from outside. He reported that his hand was slammed somehow by the front day room door. His report that [staff #1] was involved and that it was Intentional."	V 500		

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V 500	Continued From page 28 - Review on 3/12/19 of the North Carolina Incident Response Improvement System (IRIS) revealed: -A level III IRIS report for client #2's injury and allegation of abuse against staff #1 was originally submitted 3/4/19. -No documentation the allegation had been reported to the County DSS. Interview on 3/12/19 the County DSS staff stated: -To date there had been no report received from the facility of an allegation made by client #2 against staff #1. -DSS had learned of the incident from the client's DSS guardian, who had learned of the incident from client #2's biological mother. Interview on 3/15/19 the Director for Quality and Risk Management stated: -She was responsible for IRIS reporting and reporting to other required outside entities. -She had not made a report to the county DSS about client #2's allegation against staff #1. This deficiency is cross referenced into 10A NCAC 27G .1901 Scope (V314) for a Type A1 and must be corrected within 23 days.	V 500		
V 517	27E .0104(c-d) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (c) Restrictive interventions shall not be employed as a means of coercion, punishment or retaliation by staff or for the convenience of staff or due to inadequacy of staffing. Restrictive interventions shall not be used in a manner that	V 517	V517 begins on next page	

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V 517	Continued From page 29 causes harm or abuse. (d) In accordance with Rule .0101 of Subchapter 27D, the governing body shall have policy that delineates the permissible use of restrictive interventions within a facility. This Rule is not met as evidenced by: Based on record reviews and interviews 2 of 5 paraprofessional staff (#7, #8) failed to use a restrictive intervention in a manner that would not cause harm or abuse for 1 of 6 clients audited (#4). The findings are: Review on 3/12/19 of client #4's record revealed: -13 year old male. -Admission date of 9/25/18. -Diagnoses of bipolar disorder - severe with psychotic features, and oppositional defiant disorder (ODD). Review on 3/14/19 of staff #7's record revealed: -Hire date of 7/07/14. -Position, Mental Health Technician (MHT). -Handle with Care (HWC) training completed 3/06/19. Review on 3/14/19 of staff #8's record revealed: -Hire date of 1/02/12. -Position, Mental Health Technician. -HWC training completed 4/16/18 Review on 3/12/19 of a facility Incident Response Improvement System (IRIS) report for client #4 revealed: - Incident date: 3/05/19 - Incident time: 7:05pm - Provider Comments: "The patient was refusing to follow staff redirections, became aggressive,	V 517	V517 **1. The plan for correcting the specific deficiency cited.** A root cause analysis was completed on March 27, 2019 with Governing Board (GB) representative and staff involved. A Plan of Action was, subsequently, developed as follows: A. Re-educate all direct care staff on verbal de-escalation techniques and conduct demonstration and return demonstration of same as part of the training. B. Re-educate all direct care staff on Handle with Care (HWC) including increased emphasis on verbal-de-escalation techniques. **2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited.** A. All direct care staff will be re-educated by HWC trainers on de-escalation techniques. Staff will be required to perform return demonstration on techniques to fulfill competency requirements. April 7, 2019 B. All direct care staff will be re-educated by HWC trainers on HWC, regardless of their current certification for same. April 7, 2019 **3. The title of the person(s) responsible for implementing the acceptable plan of correction:** Director of Nursing **4. The monitoring procedure to ensure that the POC is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements.** Compliance with requirements is being monitored as follows: 100% of all episodes of seclusion or restraint occur are being reviewed as part of this Safety Committee meeting by video monitoring review to ensure that verbal de-escalation techniques are being utilized and to assess for the compliance with the requirements of HWC. The findings from the Safety Meeting are reported to the Quality/PI Council, the Medical Executive Committee and the Governing Board Committee at each of their respective meetings. This process will continue on a go forward basis and has no end date.	

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V 517	Continued From page 30 pushing and hitting staff members. PRT (physical restraint) was initiated for safety and patient was released once calm and compliant. Patient debriefed with the RN (Registered Nurse) and acknowledged their behavior stating, 'Hit staff,' when asked what happened to cause the restraint. When asked how they can avoid future restrictions the patient replied, 'Go to my room.' Staff noted coping skills training and environment changes to avoid future instances." Review on 3/12/19 of client #4's emergency room summary dated 3/5/19 revealed: -Reason for visit: "Lip laceration." -Diagnosis: "Facial laceration, initial encounter." -Treated with "skin glue." Review on 3/12/19 of Resident Observation Sheet dated 3/05/19 revealed: -Client #4 "went to breakfast but did not follow directions when staff asked him to be quiet. Resident [illegible] agitated. Staff tried redirecting but resident refused. Resident became verbally aggressive and was escorted out. Resident resisted and had to be restrained. Resident hit his head during restraint which busted under lip. Resident went to ER (emergency room) for most of the shift but returned." Review on 3/12/19 of Restrictive Intervention Reporting Form dated 3/05/19 revealed: -Date of incident: 3/05/19. -Time of incident: 8:26am. -Client "charged/pushed staff." -Injury noted as "cut under nose." -50 mg (milligrams) of Benadryl and Thorazine administered IM (intramuscular) Review on 3/12/19 of staff #7's written statement dated 3/05/19 revealed:	V 517		

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V 517	Continued From page 31 -"Resident was being disrespectful to staff. When asked to leave the café he became aggressive towards staff and was PRT'd (physically restrained) for safety. As he was being escorted out of the café he began to fight staff Control was lost and the wall was used as a stabilizer. After we regained control we escorted the resident to the doc station where control was lost again the wall was used as a stabilizer and that is when I noticed the resident was bleeding. He was escorted in to the Time away room." Review on 3/12/19 of staff #8's written statement revealed: -"Patient was Defiant and Refused to leave the café Became aggressive to staff, Patient was PRT'd, patient was fighting the PRT (physical restraint) tried to Bite Staff. Staff lost control avoiding Being Biten We Hit the wall patient hit face on wall trying to Bite Staff, We Regain Control ESC (escorted) patient to Quiet Room, Patient started fighting again we lost Control Hit the wall seen Blood when we was in the Quiet Room." Review on 3/12/19 of staff #12's written statement revealed: -"I walked in to the cafeteria at 8:20am to check on the Hall 400 meals due to the being a little behind schedule. When I arrived in the café the staff members were setting expectations about the noise level in the café. [Client #4] continued to talk after several verbal redirection from staff. I then intervened and ask [client #4] to take time away to regroup. [Client #4] began to curse and refused to leave. I then moved the rest of the hall to the back table and asked MHT [staff #8] and [staff #7] to talk with [client #4] about his behavior. After a minute or two [client #4] still refused to leave and stood up and through a	V 517		

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V 517	Continued From page 32 elbow at MHT [staff#7] and then proceeded to become aggressive by pushing and hitting MHT [staff #7]. The two MHT's restrained [client #4] and began to escorted him to the quiet room as they were passing by me he began to fight and it appeared to me that they tripped and landed up against the wall in the café. I assisted them in getting him off the wall and escorting him to the quiet room. Once we got to the dock station he began to fight and that when I noticed the blood on his face." Review on 3/12/19 of Internal Investigation Report dated 3/05/19 revealed: -Interview timeline: "All witnesses stated MHTs were attempting to escort [client #4] to quiet room where he began to bite the MHT and fight the restraint, and their hold of [client #4] was compromised, causing them all to hit the wall. [Client #4's] face hit the molding on the wall, causing a cut to his upper lip. Summary of evidence: "Witnesses and video review indicated that the allegation of being 'slammed' into the wall was unsubstantiated." Observation on 3/15/19 at approximately 3:00pm of video surveillance of incident was inconclusive, as camera angle at moment of injury was obstructed by hallway wall. Interview on 3/14/19 client #4 stated: -He had been injured by staff approximately 1-2 weeks earlier. -Incident took place in cafeteria at breakfast time. -He was sitting in the middle of the cafeteria and talking during breakfast. Staff #7 approached him and asked him to leave, as he was "not supposed to talk during last tray." He did not wish to leave and was then approached by staff #8 who told him to "get up." He got up and attempted to push	V 517		

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(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 517	Continued From page 33 staff #8 which resulted in a two-person restraint. He was initially restrained in the middle of the cafeteria and then was escorted out of the cafeteria and into the hallway. As they moved from the cafeteria, he attempted to bite staff #7. He was approximately 3-4 feet from the wall at that point. Staff #7 told him "you're not going to bite me" and he then "felt a push in the middle of my back by [staff #7]." His face hit a wood molding, bordering the middle of the hallway wall. He remained in a restraint for approximately "15 minutes" and a nurse evaluated him for injuries. Interview on 3/14/19 with client #6 revealed: -He had lived at facility for approximately 5 months. -He witnessed incident in cafeteria involving client #4. Incident had occurred approximately 2 weeks prior. He witnessed staff#7 and a second unknown staff restrain client #4 in middle of cafeteria and then escort client #4 into hallway where they "busted his mouth" against a wood rail along hallway wall. He did not feel that the restraint was conducted appropriately. Interview on 3/14/19 staff #7 stated: -He had been employed with company for approximately 5 years. -He was working on the morning of 3/05/19 and recalled the incident with client #4. Incident took place in cafeteria and was around breakfast time. Client #4 was "being disrespectful" and "we asked him to leave." A nurse was called and an attempt made to exit client #4 from the cafeteria. Client #4 refused to exit the area, became verbally and physically aggressive and was restrained. While client #4 was in restraint he attempted to bite staff #7 "so we placed him face first against the wall to regain control of the situation. He must've hit his face on the wall at	V 517		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20140057	A. BUILDING: _____ B. WING _____	03/20/2019

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V 517	Continued From page 34 that time." Once control was regained, he (client #4) was escorted to the quiet room by staff #7 and staff #8. Once at quiet room, injury to client #4's face was observed and client #4 was placed in a sitting restraint. -In incident involving client #4 on 3/05/19 "We had to improvise to maintain control of the situation. We can't let them go in that situation." -"It doesn't happen often, but there are those times when we have to use wall for restraining." Interview on 3/14/19 staff #8 stated: -He had been employed with company for approximately 7-8 years. -He recalled the incident with client #4. Incident took place in cafeteria. Client #4 was "being defiant" and "verbally aggressive." Attempts to de-escalate the situation failed and client #4 "pushed against [staff #7]." Staff #7 and Staff #8 then restrained client #4 and an attempt was made to escort client #4 to quiet room. While escorting client #4 from cafeteria, client #4 attempted to bite staff #7. Staff #7 and staff #8 "used the wall to gain control and he (client #4) ended up busting his lip against the molding on the wall." Once client reached the quiet room the injury was observed and client #4 was placed in a sitting restraint. -"That is a technique we are taught in the Handle with Care (HWC) training, to place person against wall to regain control." Interview on 3/15/19 with staff #12 stated: -He had been employed with company for approximately 9 years. - He recalled the incident with client #4. Incident took place in cafeteria. All clients were asked to keep noise down in order to get orders right for breakfast. He asked Client #4 to "take some time away and regroup", as client #4 was being loud.	V 517		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 517	Continued From page 35 Client #4 refused to leave and began to escalate with verbal aggression. Staff #7 and staff #8 stepped in to assist with de-escalating techniques. Client #4 stood up, sat back down, and then "stood up and bull rushed [staff #7]." Client #4 was restrained using a two person restraint in the middle of the cafeteria. An attempt was then made to escort client #4 out of cafeteria and into hallway. It appeared that client #4 "stumbled and hit the wall because they just went straight towards the wall." He (staff #12) was unable to see where client #4's face made contact with the wall due to his angle. Client #4 was then escorted to quiet room where injury was observed. Nurse was called for injury assessment and first aid. -He did not observe any techniques not outlined in the HWC training model. Interview on 3/14/19 the Director of Safety stated: -He had been a HWC Trainer since 2013-2014. -The facility conducted HWC recertifications every 6 months. -The HWC curriculum promoted the least restrictive intervention possible. -There were no techniques within HWC where the client's face should have been against the wall. Anchoring techniques may include staff's shoulder against the wall, or staff facing the wall and the client's back to the wall. Interview on 3/12/19 the Director for Quality and Risk Management stated: -She had completed an investigation of the the allegation made against two staff using improper restrictive intervention techniques. The allegation was made by client #4, following a two person restraint which resulted in a facial laceration. -According to her investigation, witnesses and video review resulted in the allegation being	V 517		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 517	Continued From page 36 unsubstantiated. Review on 3/15/19 of the Plan of Protection dated 3/15/19 and completed by the Director of Quality Compliance and Risk Management revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? Corrective Actions and Steps: Shift to shift review of correct Handle with Care techniques with all direct care staff effective immediately. This will include all physical holds and appropriate techniques as referenced in the HWC guidelines. -Describe your plans to make sure the above happens. Responsible Party for corrections and monitoring for effectiveness of same: Certified HWC Trainer." Client #4 was a 13 year old male with diagnoses of bipolar disorder - severe with psychotic features, and ODD. As staff #7 and #8 were escorting client #4 down the hall to the Quiet Room, client 4 attempted to get free. At that time, staff #7 and #8 pushed him against the wall causing his lip to get busted. The failure of staff #7 and staff #8 to use proper restraint techniques, as outlined by HWC, resulted in client #4 receiving lacerations under his nose and on the inside of his mouth requiring treatment at the Emergency Room. This deficiency constitutes a Type A1 for serious harm and must be corrected within 23 days. An administrative penalty of $3000 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 517		