STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20040012	A. BUILDING: ______ B. WING ______	06/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRYNN MARR BEHAVIORAL HEALTHCARE	**192 VILLAGE DRIVE JACKSONVILLE, NC 28546**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and complaint survey was completed on June 19, 2019. The complaint was unsubstantiated (intake #NC00147625). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and	V 105		

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V 105	Continued From page 1 recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field; This Rule is not met as evidenced by:	V 105		

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V 105	Continued From page 2 Based on record reviews and interviews, the facility failed to develop and implement written policies for adoption of standards that assure operational and programmatic performance meeting applicable standards of practice for the formal refresher training alternatives to restrictive interventions on a semi-annual basis as required by CFR §483.376(f) for 3 of 3 audited staff (Registered Nurse (RN) #1, Teacher #1, and Staff #3). The findings are: Review on 06/18/19 of the RN #1's personnel record revealed: -Hire date of 10/06/14. -Documented CPI (crisis prevention institute) training dated 09/30/18 expiration of 09/30/19. Review on 06/18/19 of the Teacher #1's personnel record revealed: -Hire date of 04/29/13. -Documented CPI training dated 06/30/18 expiration of 06/30/19. Review on 06/18/19 of the staff #3's/mental health worker's personnel record revealed: -Hire date of 02/20/12. -Documented CPI training dated 01/31/19 expiration of 01/31/20. During interview on 06/19/19 the Chief Nursing Officer (CNO) stated: -She was unaware of the requirement for staff to be trained on a semi-annual basis to include a six month refresher course for alternatives to restrictive interventions.	V 105		
V 114	27G .0207 Emergency Plans and Supplies	V 114		

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V 114	Continued From page 3	V 114		

10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES
(a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority.
(b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.
(c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies.
(d) Each facility shall have basic first aid supplies accessible for use.

This Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to ensure disaster drills were held quarterly and repeated on each shift. The findings are:

Review on 06/18/19 of facility records from June 2019 through June 2018 revealed:
- Two documented disaster drills on April 18, 2018 and September 16, 2018.

Interview on 06/18/19 the Director of Plant Operations stated:
- The facility had two 12 hour shifts (7am to 7pm and 7pm to 7am).
-Disaster drills were "only conducted semi-annually, based on joint commission standards."
- He was not aware of the DHSR (Division of Health Service Regulation) requirement for disaster drills which required drills to be held

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V 114	Continued From page 4 quarterly and repeated on each shift in a 24 hour facility. - He would follow up to ensure the disaster drills were completed as required.	V 114		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial	V 132		

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V 132	Continued From page 5	V 132		

notification to the Department.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure the Health care Personnel Registry (HCPR) is notified of all allegations against health care personnel, including injuries, which appear to be related to abuse of a resident.
The findings are:

Review on 6/18/19 and 6/19/19 of client #2's record revealed:
-13 year old female admitted 2/1/19.
-Diagnoses included Bipolar Disorder, Oppositional Defiant Disorder, and Attention Deficit Hyperactive Disorder (ADHD).

Review on 6/19/19 of the North Carolina Incident Response Improvement System (IRIS) reports between 3/1/19 and 6/17/19 revealed:
-No level III incident report for an allegation made by client #2 against Staff #2 for abuse .
-No documentation a report was made to the HCPR of an allegation by client #2 that she had been injured by Staff #2 when he threw a chair and hit her on the foot.

Refer to V366 for additional information.

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V 366	Continued From page 6	V 366		
V 366	27G .0603 Incident Response Requirments 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		

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V 366	Continued From page 7 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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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 develop and implement written policies including all requirements for governing their response as required for level I, II and III incidents. The findings are:

Review on 6/18/19 and 6/19/19 of client #2's record revealed:
-13 year old female admitted 2/1/19.
-Diagnoses included Bipolar Disorder, Oppositional Defiant Disorder, and Attention Deficit Hyperactive Disorder (ADHD).

Observations on 6/18/19 at approximately 4:30 pm revealed client #2 had a darkened area

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consistent with bruising at the base of the left toe nailbed.

Review on 6/18/19 of the facility internal incident reports for client #2 between 3/1/19 and 6/17/19 revealed:
-Client #2 had been placed in a physical restraint and seclusion on 3/14/19, 3/21/19, 3/27/19, 5/9/19, 5/15/19, and 5/19/19.
-No incident reports for an injured toe, or allegation by client #2 against Staff #2.

Review on 6/18/19 of the North Carolina Incident Response Improvement System reports for client #2 between 3/1/19 and 6/17/19 revealed:
-Only 1 Level II report of a restrictive intervention and it documented the incident date was 3/13/19.
-No Level III reports of an allegation against Staff #2 by client #2.

Interview on 6/18/19 client #2 stated:
-She had been in the facility since February 2019 and it had been "ok."
-Staff #2 had bruised her toe about 2 months ago.
-She wrote a complaint and gave it to Staff #1.
-The injury occurred when Staff #2 threw a chair on her foot because she (client #2) was not listening to him.
-Staff #1 talked to her about the complaint.
-The nurse did not look at her toe; she did not tell the nurse.
-This happended in the "incentive lounge."
-No one else saw this happen.
-She has never been hurt by any other staff.

Interview on 6/18/19 Staff #1 stated:
-She remembered client #2 telling her about Staff #2 hurting her toe.
-She (Staff #1) told the nurse.
-She could not recall when this happened.

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V 366	Continued From page 10 -She would have documented in her daily notes. Interview on 6/19/19 the Chief Nursing Officer stated: -They had no reports of allegations against staff. -All allegations were to be reported and investigated. -They had not been able to locate any documentation of an allegation against Staff #2 or a toe injury for client #2.	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	V 367		

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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 information provided in the report may be erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information required on the incident form that was 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

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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 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:

Review on 6/18/19 and 6/19/19 of client #2's record revealed:
-13 year old female admitted 2/1/19.
-Diagnoses included Bipolar Disorder, Oppositional Defiant Disorder, and Attention Deficit Hyperactive Disorder (ADHD).

Review on 6/19/19 of the North Carolina Incident Response Improvement System (IRIS) reports between 3/1/19 and 6/17/19 revealed:
-No level II incident reports for client #2 having been put in a physical restraint or seclusion on 3/14/19, 3/21/19, 3/27/19, 5/9/19, 5/15/19, or 5/19/19.

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V 367	Continued From page 13 -No level III incident report for an allegation by client #2 against Staff #2 for abuse. Interview on 6/18/19 the Director of Performance Improvement and Risk Management stated: -She entered the Level II incidents for restrictive interventions into the IRIS system. -Once entered she wrote the incident number at the top of the internal incident report. -She did not realize these reports were incomplete in the IRIS system and not sent to the LME as required. -She would follow up and correct this process. Interview on 6/19/19 the Chief Nursing Officer stated there had been no reports of allegations against Staff #2. Refer to V366 for additional information.	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 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	V 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20040012	A. BUILDING: ______ B. WING ______	06/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRYNN MARR BEHAVIORAL HEALTHCARE	192 VILLAGE DRIVE JACKSONVILLE, NC 28546

(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 500	Continued From page 14	V 500		

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 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

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 500	Continued From page 15	V 500		

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 implement a policy to assure all instances of alleged or suspected client abuse are reported to the County Department of Social Services. The findings are:

Review on 6/18/19 and 6/19/19 of client #2's record revealed:
-13 year old female admitted 2/1/19.
-Diagnoses included Bipolar Disorder, Oppositional Defiant Disorder, and Attention Deficit Hyperactive Disorder (ADHD).

Review on 6/19/19 of the North Carolina Incident Response Improvement System (IRIS) reports between 3/1/19 and 6/17/19 revealed:
-No level III incident report for an allegation by client #2 against Staff #2 for abuse .
-No documentation a report was made to the County Department of Social Services of an allegation by client #2 against Staff #2 for abuse.

Refer to V366 for additional information.