PRINTED: 06/24/2019 Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED 20040012 B. WING 06/19/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 192 VILLAGE DRIVE BRYNN MARR BEHAVIORAL HEALTHCARE JACKSONVILLE, NC 28546 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 000 INITIAL COMMENTS V 000 An annual and complaint survey was completed on June 19, 2019. The complaint was unsubstantiated (intake #NC00147625). Deficiencies were cited. DHSR - Mental Health This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric JUL 09 2019 Residential Treatment for Children and Adolescents. Lic. & Cert. Section V 105 27G .0201 (A) (1-7) Governing Body Policies V 105 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

Division of Health Service Regulation

needs; and

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

(C) the disposition, including referrals and

TITLE

(X6) DATE

STATE FORM

Weeka, Director of Risk & Performance Impravement
7/3/19

PRINTED: 06/24/2019 FORM APPROVED

Division of Health Service Regulation

STATEMEN	T OF DEFICIENCIES	(X1) DDOVIDED/GUDDUED/GU				
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	_
		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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		20040012	B. WING		00/40/0040	
NAME OF F	PROVIDER OR SUPPLIER				06/19/2019	_
TO MILE OF T	NOVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE		
BRYNNM	IARR BEHAVIORAL HEAL	THEADE 192 VILI	AGE DRIVE			
0.000.000.000.000	DEMANIONAL MEAL		ONVILLE, NC 285	346		
(Y4) ID	CLIMMADY CT		SINVILLE, INC 288	946		
(X4) ID PREFIX	(FACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION	(VE)	_
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD)	BE COMPLETE	
		OS IDENTIFICATION)	TAG	CROSS-REFERENCED TO THE APPROPR	IATE DATE	
				DEFICIENCY)		
V 105	Continued From page	1	V/ 405			_
	- Timilada i Tom page		V 105			
	recommendations;					
		and quality improvement				
	activities, including:	and quanty improvement				-
						- 1
	(A) composition and a	ctivities of a quality				ı
	assurance and quality	improvement committee;				-
	(B) written quality assu	rance and quality				-
	improvement plan;					- 1
		oring and evaluating the				- 1
	quality and appropriate	oring and evaluating the				- 1
	quality and appropriate	eness of client care,				-1
	including delineation of	client outcomes and				1
	utilization of services;					1
	(D) professional or clini	ical supervision, including				1
	a requirement that staff	f who are not qualified				1
	professionals and provi	ide direct client services				1
	shall be supervised by	a suplified the first services				1
	shall be supervised by	a qualified professional in				1
	that area of service;					1
	(E) strategies for impro-	ving client care;				1
	(F) review of staff qualif	fications and a				ı
	determination made to	grant				L
	treatment/habilitation pr					ı
	(G) review of all fatalitie	of estimation to				ı
	word being somed in	es of active clients who				L
	were being served in an	ea-operated or contracted				ı
1	residential programs at	the time of death;				ı
	<ul><li>(H) adoption of standard</li></ul>	ds that assure operational				ı
1	and programmatic perfo	rmance meeting				
	applicable standards of					
	ourpose, "applicable sta	indards of practice"				
1	means a level of compe	tence established with				
r	eference to the prevailing	ng and accepted				
r	nethods, and the degree	e of knowledge, skill and			1	
C	are exercised by other	practitioners in the field;			1	
		production in the field,				
PAGE 1						
T	his Rule is not met as e	evidenced by:			1	

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: \_ COMPLETED 20040012 B. WING 06/19/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 192 VILLAGE DRIVE BRYNN MARR BEHAVIORAL HEALTHCARE JACKSONVILLE, NC 28546 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PRFFIX (EACH CORRECTIVE ACTION SHOULD REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETE TAG DATE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY V 105 Continued From page 2 V 105 Based on record reviews and interviews, the All staff providing direct care to patients will Implemented facility failed to develop and implement written receive formal CPI refresher training on a semiby 8-18-19 policies for adoption of standards that assure annual basis. This will require additional training and operational and programmatic performance of 125-150 employees. Due to the number of completed meeting applicable standards of practice for the employees needing refresher training, staff that for all formal refresher training alternatives to restrictive work primarily on the PRTF unit will be employees prioritized and trained first, beginning in August, by 11-30-19 interventions on a semi-annual basis as required followed by additional hospital employees. by CFR §483.376(f) for 3 of 3 audited staff (Registered Nurse (RN) #1, Teacher #1, and The Director of Human Resources will be Staff #3). The findings are: responsible for monitoring expiration dates of CPI training for all staff on a monthly basis to ensure that semi-annual CPI training is current Review on 06/18/19 of the RN #1's personnel for staff. The Director of Human Resources will record revealed: schedule staff for CPI refresher training prior to -Hire date of 10/06/14. the expiration of their current training. -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

V 114 27G .0207 Emergency Plans and Supplies

restrictive interventions.

V 114

Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: \_ COMPLETED 20040012 B. WING 06/19/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 192 VILLAGE DRIVE BRYNN MARR BEHAVIORAL HEALTHCARE JACKSONVILLE, NC 28546 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 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: Disaster drills will be conducted on the PRTF Based on record review and interviews, the 7-31-19 unit on a quarterly basis for each shift. facility failed to ensure disaster drills were held Employees participating in the disaster drills will quarterly and repeated on each shift. The findings sign an acknowledgement attesting to their are: participation. Documentation of the completion of disaster drills will be maintained by the Plant Review on 06/18/19 of facility records from June Operations Department. The Director of Plant 2019 through June 2018 revealed: Operations will be responsible for monitoring the - Two documented disaster drills on April 18, completion of disaster drills to ensure that one is conducted per shift, per quarter. 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

<u>Division of Health Service Regulation</u>
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEME!	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	,
	TO COMMENTON	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		20040040	P MINO			
NAME 05.		20040012	B. WING		06/19/201	9
NAME OF	PROVIDER OR SUPPLIER		ADDRESS, CITY, STA	ATE, ZIP CODE		
BRYNN	IARR BEHAVIORAL HEAL	INCARE	LAGE DRIVE			
(X4) ID	CHMMADVETA		ONVILLE, NC 28	546		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COM	X5) IPLETE ATE
V 114	Continued From page	4	V 114			
	facility.	d on each shift in a 24 hour one ensure the disaster drills guired.				
V 132	G.S. 131E-256(G) HCF Allegations, & Protection	PR-Notification, on	V 132			
i i	REGISTRY  (g) Health care facilities Department is notified of health care personnel, unknown source, which any act listed in subdivit (which includes:  a. Neglect or abuse of facility or a person to what as defined by G.S. 1318 as defined by G.S. 1318 as defined by G.S. 1318 b. Misappropriation of in a health care facility, (b) of this section includicare services as defined hospice services as defined hospice. Misappropriation of the healthcare facility.  d. Diversion of drugs be facility or to a patient or dee. Fraud against a heal a patient or client for whoproviding services). Facilities must have evident services as defined as patient or client for whoproviding services.	of all allegations against including injuries of appear to be related to sion (a)(1) of this section.  If a resident in a healthcare from home care services E-136 or hospice services E-201 are being provided. The property of a resident as defined in subsection ing places where home by G.S. 131E-136 or ned by G.S. 131E-201  The property of a lelonging to a health care client. The care facility or against from the employee is dence that all alleged a must make every effort harm while the ss. The results of all eported to the				

Division of Health Service Regulation

1	STATEME	ENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	()(0) 14111 =	DI F. C.		
	AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY	
1				A. BUILDIN	G:	COM	PLETED
ı							
l			20040012	B. WING			
r						06	5/19/2019
l	NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE		
l	BRYNN	MARR BEHAVIORAL HEAL		AGE DRIVE			
l		MARK BEHAVIORAL REAL	INCARE	ONVILLE, NC	29546		
Γ	(X4) ID	SUMMARYSTA	TEMENT OF DEFICIENCIES				
ı	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
	TAG	REGULATORY OR LS	SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA	E	COMPLETE
				170	DEFICIENCY)	ATE	DATE
Г	1/ 12	2 0			===::::::::::::::::::::::::::::::::::::		
	V 132	Continued From page	5	V 132			
		notification to the Depa	artment				
		Trained and to the Bepe	aunent.				
		This Rule is not met as	evidenced by:				
		Based on record review	evidenced by.		The allegation of abuse by client #2 was		7-31-19
		Based on record review	s and interviews, the		reported to the Healthcare Personnel Rec	aistry	. 01 10
		Desired (LODD)	he Health care Personnel		(HCPR) on 6-20-19 (initial report) which	was	
		Registry (HCPR) is notif	fied of all allegations		followed by the 5-day investigative report		
		against health care pers	sonnel, including injuries,		submitted on 6-25-19. The allegation of a	huse	
		which appear to be related	ted to abuse of a resident.		was also submitted into the North Carolin.	а	
		The findings are:			Incident Response Improvement System	(IRIS)	
					on 6-20-19.	()	
		Review on 6/18/19 and	6/19/19 of client #2's				
		record revealed:			All allegations of abuse, neglect, or exploi	tation	
		-13 year old female adm	nitted 2/1/10		made by a patient against a Brynn Marr H	Insnital	
		-Diagnoses included Bip	olar Disardar		employee will be reported to the Health C.	are	
		Oppositional Defiant Dis	order production		Personnel Registry (HCPR), Direct-care s	taff will	
		Deficit Humanastina Dis	order, and Attention		be re-trained on the hospital policy of "Alle	eged	
		Deficit Hyperactive Disor	rder (ADHD).	1	Abuse and Neglect", including the immedia	ate	
		Deview CHOHA			notification to their supervisor and Director	r of	
		Review on 6/19/19 of the	North Carolina Incident		Risk Management and Performance		- 1
		Response Improvement	System (IRIS) reports		Improvement.		- 1
		between 3/1/19 and 6/17	'/19 revealed:	1	0. "		1
		-No level III incident repo	ort for an allegation made		Staff accused of abuse, neglect, or exploit	ation	- 1
		by client #2 against Staff	#2 for abuse .		of a patient will not provide direct patient c	are	- 1
		-No documentation a rep	ort was made to the		pending an internal investigation. The Dire	ctor of	- 1
		HCPR of an allegation by	/ client #2 that she had		Risk Management and Performance		
		been injured by Staff #2	when he throw catala		Improvement will be responsible for submit	tting	1
		and hit her on the foot.	when he threw a chair		all allegations of abuse, neglect, or exploits	ation	- 1
		and filt fier off the foot.			of patients against staff to the HCPR via ar	n initial	- 1
		Defe-4- \ /200 (			report. The initial report will be followed by	an	- 1
		Refer to V366 for addition	nal information.		investigative report within 5 days.		

Division of Health Service Regulation

STATE FORM

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STATEMENT OF DEFICIENCIES

STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MULTIPLE (	CONSTRUCTION		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	1000 - 200000000000000000000000000000000		(X3) DATE	
			A. BUILDING: _		COMP	PLETED
		20040012	B. WING		06/	19/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	710 0005		10/2010
BB\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\			LAGE DRIVE	a, ZIF GODE		
BRYNNIN	IARR BEHAVIORAL HEAL	INCARE	ONVILLE, NC 2854	•		
(X4) ID	SUMMARYSTA	ATEMENT OF DEFICIENCIES	ONVILLE, NC 2054			
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETE
				DEFICIENCY)	MAIE	DATE
V 366	Continued From page	6	V 366			
V/ 200			V 300			
V 300	27G .0603 Incident Re	esponse Requirments	V 366			
	104 NCAC 27C 00	02 INCIDENT				
	10A NCAC 27G .06	03 INCIDENT				
	RESPONSE REQUIR					
	CATEGORY A AND B					
	(a) Category A and B p	providers shall develop and				
	implement written police	cles governing their				
	shall require the provid	r III incidents. The policies				
	shall require the provid (1) attending to t	er to respond by:				
	of individuals involved i	he health and safety needs				
						1
	(3) developing ar	he cause of the incident;				
	measures according to	nd implementing corrective				1
	timeframes not to exce	od 45 dove				
		nd implementing measures				
		ents according to provider				
	specified timeframes no	of to exceed 45 days:				
		son(s) to be responsible				1
	for implementation of th	sori(s) to be responsible				1
	preventive measures;	e corrections and				- 1
		onfidentiality requirements				
	set forth in G.S. 75. Arti	cle 2A, 10A NCAC 26B,				
	42 CFR Parts 2 and 3 a	nd 45 CFR Parts 160 and				
	164; and	and 40 of 101 arts 100 and				
		ocumentation regarding				
		rough (a)(6) of this Rule.				
	(b) In addition to the red	duirements set forth in				- 1
	Paragraph (a) of this Ru	lle. ICF/MR providers				- 1
	shall address incidents a	as required by the federal				1
1	regulations in 42 CFR P	art 483 Subpart I				
(	(c) In addition to the req	uirements set forth in				
F	Paragraph (a) of this Ru	le, Category A and B				
r	providers, excluding ICF	/MR providers, shall				- 1
C	develop and implement v	written policies governing				- 1
t	heir response to a level	Ill incident that occurs				1
V	vhile the provider is deliv	vering a billable service				- 1
C	or while the client is on the	ne provider's premises				
Т	he policies shall require	e the provider to respond				1
		, to roopond				1
ision of Health	Service Regulation				-	1

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STATE FORM 6899 UE5M11 If continuation sheet 7 of 16 Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPE

AND PLAI	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURV COMPLETE	
		20040012	B. WING		06/19/2	019
	PROVIDER OR SUPPLIER  MARR BEHAVIORAL HEAL	THCARE 192 VILL	DDRESS, CITY, STAT AGE DRIVE NVILLE, NC 2854			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	BF c	(X5) COMPLETE DATE
	by: (1) immediately by: (A) obtaining the (B) making a pho (C) certifying the (D) transferring the review team; (2) convening a review team within 24 h internal review team sh who were not involved were not responsible for with direct professional services at the time of the review team shall complete follows: (A) review the condetermine the facts and and make recommendate occurrence of future incomplete follows: (B) gather other induction of the condete follows in the facts and the fact	client record; otocopy; e copy's completeness; and he copy to an internal meeting of an internal meeting of an internal meeting of the incident. The hall consist of individuals in the incident and who for the client's direct care or oversight of the client's he incident. The internal polete all of the activities as aboy of the client record to discusses of the incident ations for minimizing the idents; information needed; preliminary findings of fact of the incident. The fact shall be sent to the internal polete in the incident. The fact shall be sent to the incident. The fact shall be sent to the incident. The fact shall be sent to the incident. The fact shall be incident of the incident of the incidents of the incidents of the incidents of the incidents of the incidents. If	V 366			

Division of Health Service Regulation

STATE FORM

6899

PRINTED: 06/24/2019

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED 20040012 B. WING 06/19/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 192 VILLAGE DRIVE **BRYNN MARR BEHAVIORAL HEALTHCARE** JACKSONVILLE, NC 28546 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Continued From page 8 V 366 V 366 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 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 any other authorities required by law. This Rule is not met as evidenced by: The allegation of abuse by client #2 was 6-20-19 Based on record reviews and interviews the submitted into the North Carolina Incident facility failed to develop and implement written Response Improvement System (IRIS) on 6-20policies including all requirements for governing their response as required for level I, II and III All incidents meeting criteria for Level II and incidents. The findings are: Level III incidents (i.e., restrictive interventions, allegations of abuse, etc.) will be submitted into Review on 6/18/19 and 6/19/19 of client #2's the IRIS system within 72 hours. Direct-care staff record revealed: will be re-trained on the hospital policy of -13 year old female admitted 2/1/19. "Alleged Abuse and Neglect", including the -Diagnoses included Bipolar Disorder, immediate notification to the supervisor and Oppositional Defiant Disorder, and Attention Director of Risk Management and Performance Deficit Hyperactive Disorder (ADHD). Improvement. Staff accused of abuse, neglect, or exploitation of a patient will not provide direct patient care pending an internal investigation. Observations on 6/18/19 at approximately 4:30 pm revealed client #2 had a darkened area The Director of Risk Management and Performance Improvement will be responsible for submitting all Level II and Level III incidents into the IRIS system. The Director of Risk

Division of Health Service Regulation

Management and Performance Improvement received technical assistance from the Quality

Division	of Health Service Regu	lation				D: 06/24/201 M APPROVE
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G:	(X3) DATE COMP	SURVEY
		20040012	B. WING		06/	19/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		10/2013
BRYNNIV	IARR BEHAVIORAL HEAL	4001111	AGE DRIVE			
			ONVILLE, NC 2	8546		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETE DATE
1	consistent with bruisin nailbed.  Review on 6/18/19 of reports for client #2 be revealed: -Client #2 had been pla and seclusion on 3/14/5/9/19, 5/15/19, and 5/-No incident reports for allegation by client #2 allegation by client #2 allegation by client #2 and it documented the -No Level III reports of #2 by client #2.  Interview on 6/18/19 cli-She had been in the fa and it had been "ok." -Staff #2 had bruised he-She wrote a complaint -The injury occurred whon her foot because she listening to himStaff #1 talked to her all-The nurse did not look after her with the same with the same has never been hunterview on 6/18/19 Staff has never been hunterview on 6/18/19 Staff has never been hunterview on 6/18/19 Staff with the same with the same has never been hunterview on 6/18/19 Staff with the same with the	the facility internal incident etween 3/1/19 and 6/17/19 acced in a physical restraint 19, 3/21/19, 3/27/19, 19/19. If an injured toe, or against Staff #2.  The North Carolina Incident of a restrictive intervention incident date was 3/13/19. In an allegation against Staff and allegation against Staff ent #2 stated: Cility since February 2019  For toe about 2 months agouand gave it to Staff #1.  Then Staff #2 threw a chair of cilient #2 was not bout the complaint. The count incident ent #2 was not bout the complaint. The count incident ent #2 was not bout the complaint. The count incident ent #2 was not bout the complaint. The count incident ent #2 was not bout the complaint. The count incident ent #2 was not bout the complaint. The count incident ent #2 was not bout the complaint. The count incident ent #2 was not bout the complaint. The count incident ent #2 was not bout the complaint. The count incident ent #2 was not bout the complaint. The count incident entire incident e	V 366	Management Coordinator at Trillium F Resources LME/MCO on 6-20-19 regations of IRIS reported to the submission process of IRIS reported in the submission of the submission of the submission.  Management Coordinator at Trillium F Resources LME/MCO on 6-20-19 regations of the submission process of IRIS reported in the submission of the	arding the ports. The formance page for all	

#2 hurting her toe.

-She (Staff #1) told the nurse.

PRINTED: 06/24/2019

Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED 20040012 B. WING \_ 06/19/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

**BRYNN MARR BEHAVIORAL HEALTHCARE** 

## 192 VILLAGE DRIVE

DIVINITI	MARR BEHAVIORAL HEALTHCARE  JACKSO	ONVILLE, 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 366	Continued From page 10	V 366		
	-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 staffAll allegations were to be reported and investigatedThey had not been able to locate any documentation of an allegation against Staff #2 or a toe injury for client #2.			
	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 other individuals or authorities notified	V 367		

Division of Health Service Regulation

STATE FORM

	STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUII TIPI	E CONSTRUCTION		
	AND PLAN	N OF CORRECTION	IDENTIFICATION NUMBER:	1 2 2		(X3) DATE S COMPL	
				A. BOILDING.		COWIFE	ETED
			20040040	B WING			
ŀ			20040012	B. WING		06/1	9/2019
I	NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE		
I	BRYNNI	MARR BEHAVIORAL HEAL	4001411	AGE DRIVE			
L		- TOTAL TEAL		ONVILLE, NC 28	546		
l	(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
l	PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD F	3F	(X5) COMPLETE
l	IAG	REGOLATORTORE	SCIDENTIFTING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI	ATE	DATE
H					DEFICIENCY)		
l	V 367	Continued From page	11	V 367			
		or responding.					
			providers shall explain any				
		missing or incomplete	information. The provider				
		shall submit an update	ed report to all required				
		report recipients by the	e end of the next business				
		day whenever:					
		(1) the provider I	has reason to believe that				
		information provided in	the report may be				
		erroneous, misleading	or otherwise unreliable; or				
		(2) the provider of	obtains information				
		required on the inciden	t form that was previously				
		unavailable.					
		(c) Category A and B p	oroviders shall submit,				1
		upon request by the LM obtained regarding the	incident including				- 1
		(1) hospital recor	ds including confidential				1
		information;	as including confidential				
			ner authorities; and				
			response to the incident.				
		(d) Category A and B p	roviders shall send a copy				- 1
		of all level III incident re	ports to the Division of				- 1
		Mental Health, Develop	mental Disabilities and				- 1
		Substance Abuse Servi	ces within 72 hours of				
		becoming aware of the i	incident. Category A				
		providers shall send a c					
		incidents involving a clie	ent death to the Division of				- 1
		Health Service Regulation	on within 72 hours of				
		becoming aware of the i	ncident. In cases of				
		or restraint the provider	n days of use of seclusion				- 1
		or restraint, the provider	Shall report the death				- 1
		immediately, as required .0300 and 10A NCAC 27	7F 0104(a)(18)				
		(e) Category A and B pr	oviders shall send a				
		report quarterly to the LN	ME responsible for the				
		catchment area where se	ervices are provided				
		The report shall be subm	nitted on a form provided				
		by the Secretary via elec	etronic means and shall				1
		include summary informa	ation as follows:				- 1
		(1) medication erro	ors that do not meet the				
ic	ion of Hoalt	L C					

ANDPLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DAT	E SURVEY
ANDILAN	TO CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G:		PLETED
		20040012	B. WING _			
NAME OF E	PROVIDER OR SUPPLIER				06	5/19/2019
I WANE OF F	-KOVIDER OR SUPPLIER			STATE, ZIP CODE		
BRYNNN	IARR BEHAVIORAL HEAL	THCARE 192 VILL	AGE DRIVE			
			NVILLE, NC 2	28546		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETE DATE
V 367	Continued From page	12	V 367			
	the definition of a level (3) searches of a (4) seizures of a the possession of a clin (5) the total num incidents that occurred (6) a statement i been no reportable incidents have occurred meet any of the criteria	terventions that do not meet If or level III incident; a client or his living area; lient property or property in ent; ber of level II and level III ; and indicating that there have idents whenever no d during the quarter that as set forth in Paragraphs and Subparagraphs (1)				
	This Rule is not met as Based on record review facility failed to report a incidents to the LME rescatchment area where swithin 72 hours of becordincident. The findings at Review on 6/18/19 and record revealed:  -13 year old female admresord revealed:  -13 year old female admresord revealed:  -14 year old female admresord revealed:  -15 year old female admresord revealed:  -16 year old female admresord revealed:  -17 year old female admresord revealed:  -18 year old female admresord revealed:  -19 year old female admresord revealed:  -19 year old female admresord revealed:  -10 year old female admresord revealed:  -10 year old female admresord revealed:  -11 year old female admresord revealed:  -12 year old female admresord revealed:  -13 year old female admresord revealed:  -14 year old female admresord revealed:  -15 year old female admresord revealed:  -16 year old female admresord revealed:  -17 year old female admresord revealed:  -18 year old female admresord revealed:  -19 year old female admresord revealed:  -19 year old female admresord revealed:  -10 year old female admresord revealed:  -10 year old female admresord revealed:  -11 year old female admresord revealed:  -13 year old female admresord revealed:  -14 year old female admresord revealed:  -15 year old female admresord revealed:  -16 year old female admresord revealed:  -17 year old female admresord revealed:  -18 year old female admresord revealed:  -19 year old female admresord revealed:  -19 year old female admresord revealed:  -19 year old female admresord revealed:  -10 year old female admresord	Is and interviews, the II level II and level III sponsible for the services are provided ming aware of the re:  6/19/19 of client #2's nitted 2/1/19.  polar Disorder, sorder, and Attention rder (ADHD).  Per North Carolina Incident System (IRIS) reports 7/19 revealed: prts for client #2 having estraint or seclusion on		The allegation of abuse by client #2 was submitted into the North Carolina Inciden Response Improvement System (IRIS) of 19.  All incidents meeting criteria for Level II a Level III incidents (i.e., restrictive interven allegations of abuse, etc.) will be submitted the IRIS system within 72 hours. Direct-cawill be re-trained on the hospital policy of "Alleged Abuse and Neglect", including the immediate notification to the supervisor and Director of Risk Management and Perform Improvement. Staff accused of abuse, new or exploitation of a patient will not provide patient care pending an internal investigated. The Director of Risk Management and Performance Improvement will be responsifor submitting all Level II and Level III incident into the IRIS system. The Director of Risk Management and Performance Improvement eceived technical assistance from the Quillegal Management Coordinator at Trillium Healt	and of the state o	6-20-19

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Division of Health Service Regulation

STATEME AND PLAN	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	
			A. BOILDIN	G:	COMP	LETED
		20040012	B. WING		06/	19/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
BRYNN	MARR BEHAVIORAL HEAL		LAGE DRIVE			
		JACKS	ONVILLE, NC 2	8546		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	RF	(X5) COMPLETE DATE
	-No level III incident re client #2 against Staff:  Interview on 6/18/19 th Improvement and Risk -She entered the Level interventions into the IF -Once entered she wro the top of the internal ir -She did not realize the incomplete in the IRIS:  LME as requiredShe would follow up an Interview on 6/19/19 the stated there had been reagainst Staff #2.  Refer to V366 for additionation and the incomplete in the IRIS:  LME as requiredShe would follow up an Interview on 6/19/19 the stated there had been reagainst Staff #2.  Refer to V366 for additional incomplete in the IRIS:  10A NCAC 27D .0101 PRESTRICTIONS AND IN (a) The governing body assures the implementation of the implement policy to assure the implementation of the County Described to the County Described in the IRIS:  2.	port for an allegation by #2 for abuse.  The Director of Performance Management stated: Ill incidents for restrictive RIS system. The the incident number at acident report. The reports were system and not sent to the report of allegations.  The Chief Nursing Officer of reports of allegations.	V 367	Resources LME/MCO on 6-20-19 regar correct submission process of IRIS report Director of Risk Management and Perform Improvement will print confirmation page reports to IRIS for verification of submissions.	orts. The ormance	
F Health	Particular attention shall	be given to the use of				

AND PLAN (	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DAT	E SURVEY
			A. BUILDING:		СОМ	PLETED
		20040012	B. WING		06	5/19/2019
IAME OF PE	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		10,2010
RYNN M	ARR BEHAVIORAL HEAL	INCARE	AGE DRIVE			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ONVILLE, NC 2854			
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMP DAT
V 500	Continued From page	14	V 500			
	neuroleptic medication	S.				
	(c) In addition to those	procedures prohibited in				
	10A NCAC 27E .0102(	(1), the governing body of				
	each facility shall deve	lop and implement policy				
	that identifies:					
	<ol> <li>any restrictive</li> </ol>	e intervention that is				
	prohibited from use with	nin the facility; and				
	(2) in a 24-hour f	acility, the circumstances				
	under which staff are pr	ohibited from restricting				
	the rights of a client.					
	(d) If the governing bod	or if, in a 24-hour facility,				
4	the restrictions of client	rights specified in C.S.				
1	122C-62(b) and (d) are	allowed, the policy shall				
i	dentify:	anewed, the policy shall				
	-	restrictive interventions or				
a	allowed restrictions;					
	(2) the individual i	responsible for informing				
	he client; and					
0.50	3) the due proces	ss procedures for an				
ır	nvoluntary client who re	fuses the use of				
	estrictive interventions.	***************************************				
(6	within the facility the	tions are allowed for use				
ď	vithin the facility, the gov levelop and implement p	verning body shall				
C	ompliance with Subcha	pter 27E, Section .0100,				
w	hich includes:	pter 27 E, Section .0100,				
(1	1) the designation	of an individual, who				
h	as been trained and wh	o has demonstrated				
CC	ompetence to use restri	ctive interventions, to				
pr	rovide written authoriza	tion for the use of				
re	estrictive interventions w	hen the original order is				
re	enewed for up to a total	of 24 hours in				
ac	ccordance with the time	limits specified in 10A				
	CAC 27E .0104(e)(10)(					
(2)	sponsible for reviews	of an individual to be				
int	sponsible for reviews o terventions; and	the use of restrictive				
		ent of a process for				
of Health 6	) the establishme	ent of a process for				

PRINTED: 06/24/2019 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED 20040012 B. WING 06/19/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 192 VILLAGE DRIVE **BRYNN MARR BEHAVIORAL HEALTHCARE** JACKSONVILLE, NC 28546 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 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: The allegation of abuse by client #2 was 7-31-19 Based on record reviews and interviews, the reported to the Onslow County Department of facility failed to implement a policy to assure all Social Services on 6-20-19. instances of alleged or suspected client abuse are reported to the County Department of Social All allegations of abuse, neglect, or exploitation made by a patient will be reported to the Services. The findings are: Department of Social Services in the county where the alleged event occurred. Direct-care Review on 6/18/19 and 6/19/19 of client #2's staff will be re-trained on the hospital's "Alleged record revealed: Abuse and Neglect" policy, including the -13 year old female admitted 2/1/19. immediate notification to the supervisor and -Diagnoses included Bipolar Disorder, Director of Risk Management and Performance Oppositional Defiant Disorder, and Attention Improvement. Staff accused of abuse, neglect, Deficit Hyperactive Disorder (ADHD). or exploitation of a patient will not provide direct patient care pending an internal investigation. Review on 6/19/19 of the North Carolina Incident Response Improvement System (IRIS) reports The Director of Risk Management and Performance Improvement will be responsible between 3/1/19 and 6/17/19 revealed: -No level III incident report for an allegation by for ensuring that allegation of abuse, neglect, or exploitation by hospital staff are reported to client #2 against Staff #2 for abuse . Onslow County Department of Social Services. -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.