

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20140058</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/13/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>STRATEGIC BEHAVIORIAL CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3200 WATERFIELD DRIVE GARNER, NC 27529</b>
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V 000	INITIAL COMMENTS  A Complaint Survey was completed on November 13, 2019. The complaint was unsubstantiated (Intake #NC00156578). A deficiency was cited.  This facility is licensed in the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment Center for Children and Adolescents.	V 000		
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	V 367		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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V 367	<p>Continued From page 1</p> <p>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:</p> <p>(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or</p> <p>(2) the provider obtains information required on the incident form that was previously unavailable.</p> <p>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:</p> <p>(1) hospital records including confidential information;</p> <p>(2) reports by other authorities; and</p> <p>(3) the provider's response to the incident.</p> <p>(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).</p> <p>(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:</p> <p>(1) medication errors that do not meet the definition of a level II or level III incident;</p> <p>(2) restrictive interventions that do not meet</p>	V 367		

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V 367	<p>Continued From page 2</p> <p>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.</p> <p>This Rule is not met as evidenced by:                      Based on record review and interview, the facility failed to ensure an incident report for all level II incidents was completed and submitted within 72 hours of becoming aware of the incident. The findings are:</p> <p>Review on 11/12/19 of Client #4's record revealed:</p> <ul style="list-style-type: none"> <li>- admission date: 5/24/19</li> <li>- diagnoses of Post Traumatic Stress Disorder, Mood Disorder, Vitamin D deficiency, Constipation and Insomnia</li> <li>- documentation from a "Judicial Appeal" dated 10/3/19 with documentation that Client #4:                             <ul style="list-style-type: none"> <li>- has had an increase in the frequency and severity of his outbursts and aggression.</li> <li>- saw dominance as a motivation to fight</li> <li>- had episodes of running up and down the halls, yelling during relaxation time</li> <li>- a behavior plan dated 5/24/19 documenting Client #4 utilized walking up and down the halls to help calm himself</li> </ul> </li> </ul>	V 367		

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V 367	<p>Continued From page 3</p> <p>During an interview on 11/12/19 MHT#1 (Mental Health Technician) reported:</p> <ul style="list-style-type: none"> <li>- the 500 unit hallway carpet was being replaced with hardwood floors</li> <li>- clients were relocated to the cafeteria</li> <li>- client #4 refused to be in the cafeteria with the group</li> <li>- he left out of the cafeteria to the hallway in front of the cafeteria</li> <li>- she followed him to redirect him back to the cafeteria</li> <li>- MW#1 (maintenance worker) was in the hallway working</li> <li>- MW#1 stood between her and client #4</li> <li>- MW#1 said client #4 was being unsafe pacing up and down the hallway</li> <li>- client #4 did not say anything but continued to pace</li> <li>- she told client #4 to calm down and talk with her so they could find a solution</li> <li>- client #4 asked how he was being unsafe</li> <li>- DRNC (Disability Rights of North Carolina) came down the hallway</li> <li>- DRNC &amp; MW#1 had words</li> <li>- MW#1 left the hallway</li> <li>- client #4 left with the Patient Advocate</li> </ul> <p>During an interview on 11/13/19, MW#1 reported:</p> <ul style="list-style-type: none"> <li>- on 10/25/19, he was walking along the corridor outside the dining area and saw Client #4 walking towards one of the locked doors at the end of the corridor</li> <li>- he knew Client #4 and his hall mates were assigned to be in the dining area because the floor on their hall was being replaced</li> <li>- Client #4 had already kicked open three other locked hallway doors in the past 2 months; once as recently as 2 or 3 days before this incident. Client #4 had also tried to kick open other doors without success. MW#1 knew</li> </ul>	V 367		

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V 367	<p>Continued From page 4</p> <p>because he was the person who replaced the doors.</p> <ul style="list-style-type: none"> <li>- he stepped in front of Client #4 and redirected him back to the dining area. He did not immediately see the Mental Health Technician (MHT#1) assigned to work with this client. He never put his hands up or on Client #4. He said nothing other than that Client #4 should return to the dining area. He wanted to prevent Client #4 from getting to the doors and trying to kick them open.</li> <li>- Client #4 was cursing at him calling him a "f_____g old man"</li> <li>- at that point a DRNC worker told him he shouldn't be interacting with the kids because he wasn't trained. He informed her he was trained in the same way as all other staff of the agency. He then saw MHT#1 come out of the dining room area to get Client #4 so he backed off the situation. He normally did not get involved in situations because MHTs were always present with the clients. He only intervened as he did not immediately see the MHT and he wanted to prevent Client #4 from doing additional property damage.</li> </ul> <p>During an interview on 11/13/19 Client #4 reported:</p> <ul style="list-style-type: none"> <li>-on 10/25/19 he was "kinda mad" because a staff person had made fun of him in front of everyone (Note: Client #4 was on "Therapeutic Interventions" which meant he was supposed to be alone and not interacting with the other clients on his hall. The staff person noted had told other clients who were playing cards with him to move away and redirected Client #4 to another activity.)</li> <li>- he got up to walk because he was mad and MW#1 stood in front of him and said "go ahead, hit me take your best shot"</li> <li>- he did not say anything to MW#1</li> </ul>	V 367		
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V 367	<p>Continued From page 5</p> <ul style="list-style-type: none"> <li>- acknowledged he had previously broken doors on the units when he was mad</li> <li>- that day he only wanted to speak with the DRNC worker who had just walked onto the hall</li> </ul> <p>During an interview on 11/13/19, Client #4's Clinician reported:</p> <ul style="list-style-type: none"> <li>- he was involved in the meeting after the incident occurred</li> <li>- Client #4 has frequently kicked in the metal doors on the halls in the facility</li> <li>- Client #4 frequently misinterpreted other's actions and words</li> </ul> <p>During an interview on 11/12/19, the Director of Compliance and Risk Management (DOC/RM) reported:</p> <ul style="list-style-type: none"> <li>- a DRNC worker reported an incident to her on 10/25/19 involving Client #4 and a maintenance worker (MW#1). The DRNC worker reported seeing MW#1 blocking Client #4 from walking down a corridor near the dining room. She reported Client #4 was not exhibiting any out of control behaviors; he was just walking in the corridor. She believed the MW#1 should not have engaged with Client #4 because she did not believe he was trained to do so. She also reported MW#1 was not engaged therapeutically with Client #4. The DRNC worker said she heard MW#1 say something but wasn't sure what. She said she asked Client #4 and he reported MW#1 said "go ahead, hit me, take your best shot."</li> <li>- she (DOC/RM) convened a meeting with Client #4, Client #4's Therapist, MW#1, MW#1's supervisor, Patient Advocate, Program Coordinator, herself, their trainer in the Nonviolence course they teach all employees and the DRNC worker immediately to address the concerns and to develop a plan of action</li> <li>- there was no documentation of this meeting</li> </ul>	V 367		

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V 367	Continued From page 6  - MW#1 was retrained in their Nonviolence training which included de-escalation techniques - they did not have documentation of this additional training - she did not write or submit an incident report for this situation - she did not see the DRNC concern as an accusation of abuse and therefore did not report the incident	V 367		