STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHH0976	A. BUILDING: _____ B. WING _____	10/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA DUNES BEHAVIORAL CENTER	2050 MERCANTILE DRIVE LELAND, NC 28451

(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 A complaint and follow up survey was completed on October 15, 2019. Two of the complaints were unsubstantiated (intakes #NC00154675, #NC00156317). Four of the complaints were substantiated (intakes #NC00155874, #NC#00156769, #NC00156842, #NC00155888). 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	*Carolina Dunes Behavioral Center 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. Please note that 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 monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; and 4) The title of the person responsible for implementing the acceptable plan of correction.* V118 begins here **1) The plan for correcting the specific deficiency cited** A. All nursing staff with medication administration duties were re-educated, through in-service training and memorandum, on the expectations that: (1) medications will be administered as ordered, (2) medications will be recorded on each client's MAR immediately after administration, (3) medication entries that are documented after completion of the nurse's shift shall be documented as "late entry" and reason for late entry shall be documented, (4) Nursing staff who remain out of compliance will be addressed through the progressive disciplinary process. B. The Pharmacy staff were apprised of this finding of lack of availability of an ordered medication through meeting with the Director of Compliance/Quality/Risk and reminded of the need to make medications available, as ordered. **2) The procedure for implementing the acceptable plan of correction for the specific deficiency cited** A. 100% of nursing staff with medication administration duties were re-educated, through in-service and memorandum, on the expectations that (1) medications will be administered as ordered. (2) medications will be recorded on each client's MAR immediately after administration, (3) medication entries that are documented after completion of the nurse's shift shall be documented as "late entry" and reason for late entry shall be documented, (4) Nursing staff who remain out of compliance will be addressed through the progressive disciplinary process. B. The Pharmacy staff were apprised of this finding of lack of availability of an ordered medication through meeting with the Director of Compliance/Quality/Risk and reminded of the need to make medications available, as ordered. V118 continues below	November 14, 2019
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and	V 118		

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V 118	Continued From page 1 (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure medications were administered as ordered and recorded on each client's MAR immediately after administration affecting 5 of 9 audited clients (#2, #3, #4, #5, and #9). The findings are: Finding #1: Review on 10/10/19 of client #5's record revealed: -13 year old female admitted 9/3/19. -Diagnoses included Post Traumatic Stress Disorder (PTSD) unspecified, Disruptive Mood Dysregulation Disorder (DMDD), Attention Deficit Hyperactive Disorder (ADHD). -Order dated 9/3/19 for Latuda 60 mg (milligrams) twice daily. (Mental/mood disorders i.e. schizophrenia, depression associated with bipolar disorder) -Order dated 9/3/19 for Depakote ER (extended release) 500 mg twice daily. (Mood) -Order dated 10/1/19 at 11am to discontinue Depakote ER 500 mg twice daily. -Order dated 10/1/19 for Depakote ER 750 mg at bedtime. Review on 10/10/19 of client #5's September and October 2019 MARs revealed:	V 118	V118 continued **3) The monitoring procedure for implementing the acceptable plan of correction for the specific deficiency cited** 100% of PRTF MARs will be audited on a weekly basis for evidence of compliance with the requirements that: (a) medications will be administered as ordered and immediately recorded on the client's MAR and (b) medications documented after the nurse's shift will be delineated as "late entry" and reason for this late entry shall be documented. Results of this audit will be reported weekly into the Morning Meeting of Hospital Leadership, monthly to Quality Council and MEC, and quarterly to the Governing Board at each of their respective meetings. This review of this monitor will continue for 90 days. If the monitor is sustained at an average compliance rate of 95% or above, the frequency will reduce to a review of 30% of PRTF MARs on a monthly basis with reports to the Quality Council and MEC and quarterly to the Governing Board. If the findings fall below the 95% expected results, a 100% review frequency will be reinstated until compliance is, again, at 95% or above. **4) Title of the person responsible for implementing the acceptable plan of correction** Director of Nursing	

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V 118	Continued From page 2 -No documentation Latuda 60 mg had been administered on 9/10/19 and 9/14/19. -Electronically printed entry on the October 2019 MAR for Depakote ER 500 mg twice daily had the 500 mg dosage crossed out and 750 mg hand written with "10/2" hand written below this dosage. The medication had been documented as administered twice daily 10/1/19 - 10/5/19. Finding #2: Review on 10/10/19 of client #3's record revealed: -17 year old male admitted 4/19/19. -Diagnoses included DMDD and Major Depressive Disorder. -Order dated 4/19/19 for Seroquel 50 mg once daily. (Atypical anti-psychotic) -Order dated 4/19/19 for Seroquel 150 mg once daily. Review on 10/10/19 of client #3's September MAR revealed: -No documentation Seroquel 50 mg had been administered on 9/08/19. -No documentation Seroquel 150 mg had been administered on 9/08/19. Finding #3 Review on 10/10/19 of client #2's record revealed: -10 year old female admitted 7/22/19. -Diagnoses included DMDD, Conduct Disorder childhood-onset type, ADHD, Major Depressive Disorder by history. -Physician Order dated 7/23/19 for Vitamin D2 50,000 Units weekly on Sunday. (Vitamin D deficiency) -Physician Order dated 7/23/19 for Prozac 30 mg once daily. (Depression)	V 118		

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V 118	Continued From page 3 Review on 10/19/19 of client #2's September 2019 MAR's revealed: -Vitamin D2 had not been given on 9/22/19 and 9/29/19 as ordered. -Prozac had not been given on 9/17/19 - 9/18/19 and 9/29/19-9/30/19. Finding #4: Review on 10/10/19 of client #4's record revealed: -16 year old female admitted 8/24/19. -Diagnoses included PTSD, DMDD, ADHD, Bipolar Disorder, Anxiety. -Order dated 9/11/19 for Flexeril 5 mg at night. (Muscle relaxant) Review on 10/10/19 of client #4's September 2019 MAR revealed: -Flexeril had not been given on 9/16/19 and 9/17/19. -Staff documented Flexeril had not been given because all automated medication dispensing systems had been checked and the medication was not available. Finding #5: Review on 10/10/19 of client #9's record revealed: -17 year old female admitted 4/11/19. -Diagnoses included Bipolar Disorder, PTSD, Conduct Disorder. -Order dated 8/06/19 for Magnesium Gluconate 500 mg at night.(Magnesium deficiency) -Order dated 5/14/19 for Melatonin 9 mg at night. (Sleep disruption) -Order dated 4/12/19 for Metformin 500 mg twice daily. (Blood sugar) -Order dated 4/12/19 for Omega-3 1000 mg three times daily. (Fish oil supplement) -Order dated 9/12/19 for Zinc Gluconate 50 mg	V 118		

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V 118	Continued From page 4 once daily. (Zinc deficiency) -Order dated 4/12/19 for Zyrtec 10 mg once daily. (Allergies) -Order dated 4/12/19 for Clonidine Oral 0.1 mg twice daily. (Anti-hypertensive, used to treat ADHD) -Order dated 4/12/19 for Eucerin applied twice daily. (Dry skin) -Order dated 5/14/19 for Vitamin D2 50,000 units once weekly. (Vitamin D deficiency) Review on 10/10/19 of client #9's September 2019 MAR revealed: -No documentation Zyrtec 10 mg had been administered on 9/29/19 at 7pm. - No documentation Magnesium Gluconate 500 mg had been administered on 9/29/19 at 8pm. -No documentation Clonidine Oral 0.1 mg had been administered on 9/29/19 at 7pm. -No documentation Vitamin D2 50,000 units had been administered on 9/04/19 at 8am. -No documentation Melatonin 9 mg had been administered on 9/29/19 at 8pm. -No documentation Metformin 500 mg had been administered on 9/29/19 at 7pm. -No documentation Omega-3 1000 mg had been administered on 9/29/19 at 7pm. - No documentation Zinc Gluconate 50 mg had been administered on 9/29/19 at 7pm. -No documentation Eucerin had been administered on 9/04/19, 9/09/19 - 9/11/19, 9/16/19 - 9/18/19, 9/29/19 at 8am. -No documentation Eucerin had been administered on 9/04/19, 9/10/19, and 9/29/19 at 8pm. Interview on 10/11/19 the Registered Nurse stated: -A blank in the MAR would mean it wasn't administered.	V 118		

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V 118	Continued From page 5 -She was often called about blank initial boxes on MARs for medications on a shift she had worked. -She would initial the blanks if she had worked that shift. -She did not always remember specifically that she gave the medication she was initialing as given. -They were not required to note these were late entries. -After the blanks are initialed there was no way to tell if the medication had been documented immediately after it had been given, or documented at a later time. Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician. [This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.]	V 118		
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	V 314	V314 begins here **1) The plan for correcting the specific deficiency cited** All direct care staff will be re-educated on the expectation related to the supervision of, specialized interventions and coordination of treatment of clients. A monitoring mechanism to assess for compliance with expectations related to: a) Patient supervision including, 15-minute checks, and b) securing contraband including lancets used for blood glucose checks, will be implemented. V314 continued below	November 7, 2019

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V 314	Continued From page 6 treatment and specialized substance abuse and mental health therapeutic care. These therapeutic interventions and services shall be designed to address the treatment needs necessary to 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 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, observations, and interviews, the facility failed to ensure supervision, specialized interventions, and coordination with other individuals and agencies responsible for the client treatment affecting 5 of 9 clients audited (clients #1, #2, #3, #7, #8). The findings are:	V 314	V314 continued **2) The procedure for implementing the acceptable plan of correction for the specific deficiency cited** A)100% of direct care staff will be re-educated through in-service on the expectation related to the supervision of, specialized interventions and coordination of treatment of clients specific to a)Patient supervision requirements including, 15-minute checks, and b)securing contraband including lancets used for blood glucose checks. B) Policy 1300.22 Room Searches has been reviewed and re-education provided to all direct care staff prior to their next scheduled shift. C)Safety searches/room checks for contraband will be conducted daily during each shift per policy and will be signed off on by the assigned unit nurse. D)Staff not meeting above expectations will be disciplined using the Hospital's progressive disciplinary process. **3) The monitoring procedure to ensure that the plan of correction is effective, and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements** Monitoring mechanisms to assess for compliance with expectations have been established whereby: On a Monday through Friday basis with activities on F, S, and Sunday incorporated into Monday's report, compliance will be assessed for: a) Accomplishing 15-minute checks per policy requirement of direct visualization of all patients .(through camera review) b) On a daily basis, securing contraband including lancets used for blood glucose checks during nursing care (through camera review). c) On a daily basis, Milieu Mangers will inspect a sample of room checks to ensure proper procedures were performed. Results will be shared on a Monday through Friday basis with the Morning Meeting, a monthly basis to the Quality Council and Medical Executive Committee, and on a quarterly basis to the Governing Board at each of their respective meetings. (V314 continued on next page)	

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V 314	Continued From page 7 Finding #1: Review on 10/15/19 of client #8's record revealed: -15 year old male admitted 12/7/18. -Diagnoses included Unspecified Bipolar Disorder; Reactive Attachment Disorder; Post Traumatic Stress Disorder (PTSD); Oppositional Defiant Disorder (ODD). -8/19/19 the Physician Assistant documented, "States he (client #8) used a blood sugar lantus needle to create a tattoo on his R (right) arm approx (approximately) 1.5 weeks ago using playing card ink and needle that was used directly before by a peer for the same thing - did not wash/sanitize... (CRI) on R upper extremity... lacerations have many "prickets" of purulent material - no active discharge. Very aggravated & erythematous & swollen skin surrounding all 3 letters... Get vaccine records ASAP (as soon as possible) for tdap (tetanus vaccination) status. 1 g (gram) rocephin (antibiotic) IM (intramuscular injection) now then Bactrim DS (antibiotic) BID (twice daily) x (for) 14 days... Mupirocin(antibiotic ointment) & clean dressings BID x 14 days. HIV (human immunodeficiency virus), Hep B & C (hepatitis), CBC w/diff (complete blood count with differential), CMP (comprehensive metabolic panel). Will monitor closely. Infectious dz (disease) nurse notified." Observations on 10/15/19 at approximately 4 pm revealed 3 letters "CRI" tattooed on client #8's right upper arm. Interview on 10/15/19 client #8 stated: -He was in room 303 when he did his tattooing. -One of the staff saw his arm and reported to the nurse. His arm was showing signs ofinfection. -He received high doses of antibiotics and a	V 314	(V314 continued from prior page) These monitoring activities will continue for 90 days. If the results of any of the three monitors are at an average compliance rate of 95% or above, the frequency of that monitor will reduce to a review of 30% sample on a monthly basis with reports to the Quality Council and MEC and quarterly to the Governing Board. If any of the findings fall below the 95% expected results, a 100% review frequency will be reinstated for that monitor out of compliance until compliance is, again, at 95% or above. **4) The title of the person responsible for implementing the acceptable plan of correction.** Director of Nursing	

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V 314	Continued From page 8 "shot." -He had been tattooing his arm for a week before it was identified by the nurse. He used a "needle" he got from client #3, who had gotten it from a peer who did blood sugar checks. -He had tattooed "CRI" on his arm and had planned to tattoo "P" but did not get to finish. -They did a "strip search" of the halls. He did not know if they found any sharps. -He returned the "needle" to client #3. He only used the "needle" one time. -He did not know if his guardian was notified. -He tattooed his arm while in the bathroom. He would be in the bathroom 30 minutes when tattooing. The staff did not check. He had been in a peer's room for about 2 hours on a recent Saturday night during third (3rd) shift and staffdid not check. Normally staff walked by the door and peeked in. Staff sat in the hall, did nothing, and slept. Finding #2: Review on 10/15/19 of client #7's record revealed: -16 year old male admitted 8/9/19. -Diagnoses included Disruptive Mood Dysregulation Disorder (DMDD) and Conduct Disorder. -8/19/19 Consultation form read: "Reason for Consultation: Stuck w/dirty needle R hand pain." The Physician Assistant documented, "Pt (patient) reports creating 2 homemade tattoos on L (left) forearm yesterday w/a (with a) pen spring & ink. Used a BS (blood sugar) lantus from another pt (used one) at first - "only 1 prick" then did the rest w/pen supplies. Learned in jail... L forearm: approx (approximately) 2" x 1" cross & ... 1.5" arrow superior to that. Erythematous and aggravated w/ some residual ... dots but no ... D/C (discharge) or sx (symptoms) of inf	V 314		

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V 314	Continued From page 9 (infection) at this time... HIV, Hep B & C testing w/ CBC w/diff & CMP... mypirocin & bandage changes BID x 14 days. Bactrim DS BID x 14 days... get vaccine records ASAP for tdap status. Will monitor closely." -Observations on 10/15/19 at approximately 3 pm revealed client #7 showed surveyors markings of an arrow and cross tattooed on his left forearm. Interview on 10/15/19 client #7 stated: -He acquired an ink pen from a peer, took the spring from pen, and used pen ink to do a tattoo. He had a "finger prick" from another client but chose not to use it. He told the doctor he had not used the needle. -A room search was done about 4 or 5 days after he was treated by the physician and the "finger prick" was found in his room. -It took him over 2 days to do his tattoo. He did this in the bathroom. He was probably in the bathroom maybe 30 to 40 minutes when tattooing. Staff checked on the clients every 15 minutes, but sometimes, if they did not see a client, they would ask peers, "where is so and so?" and the peer would say "bathroom" and staff would write down "bathroom" and not check. -The doctor had to do a HIV test because they did not know what he had used. -A nurse was with the doctor; she was the first to see his arm. She saw his arm probably the day prior to him seeing the doctor. She saw his arm when giving his meds. He usually wore a jacket, but that day his arm was exposed. He had been working on his tattoo about 3 days before the nurse saw it. -He got the lancet from client #1. He knew client #1 was a diabetic so he asked him to "grab me a needle." -He could have gotten a lancet from former client	V 314		

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V 314	Continued From page 10 (FC) #17 because he, too, had a lancet from client #1 and was tattooing himself. -He had not been asked where he got the lancet found in his room. He had the lancet in his comfort box about 5 or 6 days before it was found. -He was in room 400 when this happened. They found the lancet in his room during the "whole hall search." This was the only "whole hall search" done. -It was very common for peers to swipe pens from staff and teachers. It was pretty easy to do. Client #7 gave the example, he would find a pen dropped by the staff. -He knew client #3, who was on the 300 hall, was tattooing. There were 3 or 4 kids on the 300 hall doing this, but he did not know their names. They were using either a pen or lancet to tattoo. Finding #3: Review on 10/15/19 of client #3's record revealed: -17 year old male admitted 4/19/19. -Diagnoses included DMDD and Major Depressive Disorder. -8/19/19 Consultation form read: "Reason for Consultation: L forearm-self tatoo infx." The Physician Assistant documented, "Pt (patient) reports using the needle from an FSBS (blood sugar) device (lancet) to create a tatoo w/ ink from playing cards - approx (approximately) 1.5 weeks ago. Now has pain to the area, erythema, swelling, warmth ...L forearm: 'A' 'Z' two smaller linear wounds - surrounding tissue ...very erythematous and aggravated and inflammed. 0 percent drainage at this time. Wounds are not scabbed over but are not wet either... Localized. 0 cellulitis ...get copy of medical records (vaccine records) for tdap status. 1 gram of Rocephin IM now then Bactrim DS BID x 14 days ...Will	V 314		

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V 314	Continued From page 11 monitor very closely ...HIV, Hepatitis B & C, CBC w/diff & CMP. Infectious dz (disease) nurse notified by nurse on unit." -Observations on 10/14/19 at approximately 2:30pm revealed client #3 showed surveyors markings of the letters "A" and "Z" on his left forearm. Interview on 10/14/19 client #3 stated: -He obtained needles from other clients known to complete blood sugar checks. -Ink for the tattoos was obtained using gaming cards and alcohol pads to disinfect the needles were acquired from staff. -He completed tattoos on four different clients, utilizing a different needle for each individual . -Tattoos were completed in exchange for snacks . Finding #4: Review on 10/14/19 of client #1's record revealed: -17 year old male admitted 6/18/19. -Diagnoses included Major Depressive Disorder Recurrent Moderate; Generalized Anxiety Disorder, Alcohol Use Disorder Unspecified; Opioid Use Disorder Unspecified and Diabetes Type II. -Physician order for blood sugar checks twice a day. -Person Centered Profile updated 9/17/19 listed participation in bi-weekly family therapy. -Family Therapy session notes dated 6/28/19, 7/23/19, 8/26/19, 9/12/19, 9/18/19 and 9/30/19. -No additional family therapy notes to support the bi-weekly standard. Interview on 10/14/19 client #1 stated: -Nurses had given him the lancet to prick his own finger.	V 314		

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V 314	Continued From page 12 -Nurses felt it would be better if he pricked his own finger since he knew how to do it. -After placing the lancet on the medication cart, he took the lancet back when the nurse was not looking. -There was only one nurse who did not allow him to prick his own finger. -He gave his used lancets to other clients for no reason and traded some for snacks. -Clients would stick themselves with the used lancet until a full image appeared. -Some clients got infections after using the lancets for tattoos. -He continued to prick his own finger with a lancet after a lancet was found in a client's room. -He took about 7 lancets and gave them to client #3, client #6, client #12, and FC #17. -One nurse interviewed him and asked him to whom he had given the needles. He told her and there were no consequences. Finding #5: Review on 10/14/19 of client #2's record revealed: -10 year old female admitted 7/22/19. -DMDD; Conduct Disorder Childhood-onset type; ADHD, Major Depressice Disorder by history. -Person Centered Profile updated 9/17/19 listed paticipation in bi-weekly family therapy. -Family therapy notes dated 9/13/19, 9/23/19 and 10/10/19. -Family therapy admission form dated 7/22/19 listing family therapy sessions two times per month. -No family therapy sessions notes for August 2019. Review on 10/15/19 of "Carolina Dunes Behavioral Center Room Check" and "... Midnight Floor Census" forms between 8/16/19 and	V 314		

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V 314	Continued From page 13 8/21/19 revealed: -8/16/19: 1. Room 401 -Contraband: Needle, pencils -Occupants: None -8/19/19: 1. Room 400 -Contraband: Needle, wire, ink, pen -Occupants: client #7, client #11 2. Room 303 -Contraband: Staple, ink, and paper clip -Occupants: client #8, FC #22 3. Room 308 -Contraband: Pen -Occupants: FC #20, client #13 -8/21/19: 1. Room 402 -Contraband: Lancet, cards -Occupants: client #14, client #16 2. Room 403 -Contraband: Lancet case, mattress B split -Occupants: client #23, FC #21 3. Room 404 -Contraband: Markers, paper clips, ink, shank, lancet, lancet case -Occupants: client #1, client #12 4. Room 405 -Contraband: Lancet, pens -Occupants: clients #6, client #10 5. Room 406 -Contraband: Markers, pens, paper clips -Occupants: client #15, FC #17 6. Room 408 -Contraband: Cards, ink -Occupants: FC #18, FC #19 Review of Safety Committee documentation between 8/16/19 and 8/21/19 revealed: -A "Health Incident Review Report" for incident on 8/16/19 at 9:45 am documenting, "Staff member	V 314		

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V 314	Continued From page 14 stuck with a sharp object (lancet) found in a client's comfort box." Client name not documented. "Person Completing Report" signed 8/16/19. "Reviewed by Supervisor" signed 8/19/19. -8/20/19 Safety Committee review of incidents documented client #7 "SIB (self-injurious behavior)/contraband, scratched (tattoo) in L (left) forearm, hit wall w/R (with right) hand, slight swell/bruise 4th and 5th digit... No documentation the client used a lancet or actions to follow up client #7's use/possession of contaminated lancets. Interview on 10/9/19 the Director of Compliance/Quality/Risk/Risk Management (Q/RM) stated: -It had been identified on 8/16/19 that client #1 had taken a lancet after checking his blood sugar. This was identified after a staff had been stuck with the lancet that was in client #1's comfort box. He gave a nurse's name, but when interviewed, this nurse denied this happened. -They had not been able to determine the nurse working when this happened. Containers to dispose of contaminated sharps had been added to the medication carts. -There had not been an investigation to include client interviews for tattooing using contaminated lancets because no one had reported this had occurred. Interview on 10/15/19 the Director of Nursing stated: -She was not able to identify clients who had been treated for self tattooing usingcontaminated lancets. -She would have to look at incident reports with the Director of Q/RM to identify any such clients. Continued interview on 10/15/19 the Director of	V 314		

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V 314	Continued From page 15 Q/RM stated: -She was able to find a Level 1 incident that identified client #7 had self tattooed. -There were no other reports of clients self tattooing using contaminated lancets. -Room searches were done daily. Review on 10/2/19 of a Plan of Protection signed by the Chief Executive Officer (CEO) dated 10/15/19 revealed: - "What immediate action will the facility take to ensure the safety of the consumer in your care? -To ensure no present harm, safety searches/room checks for contraband will be conducted as per policy and will be signed off by the nurse assigned to each unit. -If during the searches any item is found that should not be in the possession of the client, a mini RCA (root cause analysis) will be completed to determine any causation. -Re-education to all direct care staff will be conducted on the need to escalate any contraband items found during room searches via completion of an incident report AND immediately texting and/or emailing the Risk Manager and CEO. -A review of all client charts from this timeframe will be reviewed to ensure all clients have been identified and if required, follow-up provided." - "Describe your plans to make sure the above happens. -Each nurse assigned to each until (unit) will be required to authenticate that this process is being conducted by signing off on each safety search performed. -Oversight of the above procedures by the CEO and Risk Manager." Client #1 was a 17 year old male admitted	V 314		

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V 314	Continued From page 16 6/18/19 with diagnoses that included Major Depressive Disorder Recurrent Moderate; Generalized Anxiety Disorder, Alcohol Use Disorder Unspecified; Opioid Use Disorder Unspecified and Diabetes Type II. Client #1 had an order for blood sugar checks twice a day and was allowed to prick his finger when the nurses checked his blood sugar. Client #1 stated he would place his used lancets on top of the medication cart, then take them when the nurse became distracted. Client #1 stated he had taken at least seven used lancets and given them to client #3, client #6, client #12, and FC #17 for tattooing. The facility became aware client #1 had taken a lancet on 8/16/19 when a staff member was punctured by a used lancet inside client #1's comfort box. The only reported action taken was to put a receptacle on top of the medication cart to dispose of used lancets. On 8/19/19 clients #3, #7, and #8 were treated for infections and tested for blood borne disease transmission due to the use of contaminated lancets to self tattoo. The Director of Q/RM stated there had been no reports of self-tattooing with contaminated lancets, therefore, no investigation or further actions had been done. Clients #7 and #8 reported they were able to self-tattoo because staff did not make visual contact during the 15 minute checks. The clients also reported at least 2 discharged peers had also used the contaminated lancets to self tattoo. Between 8/16/19 and 8/21/19 needles/lancets were documented during routine daily room checks in 6 different rooms occupied by 10 different clients. Other contraband items clients reported they used to self tattoo were found in an additional 4 rooms occupied by an additional 8 clients. There was no follow up documented with the discovery of this contraband. The facility's failure to closely supervise client #1 to perform	V 314		

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V 314	Continued From page 17 blood sugar checks resulted in multiple client's having possession and use of contaminated lancets to self-tattoo. The subsequent failure to supervise, identify, and follow up on the possession/use of contaminated lancets resulted in serious harm to 3 clients who developed infections from self-tattooing, and serious neglect to follow up at least 2 discharged clients reported by their peers to self tattoo with contaminated lancets. This deficiency constitutes a Type A1 rule violation for serious harm and neglect and must be corrected within 23 days. An administrative penalty of $3,000.00 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		
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;	V 366	V 366 begins here **1) The plan for correcting the specific deficiency cited** A) Policy 600.00 Completion of Incident Reports was reviewed by the leadership team and determined to not be in need of revision. 100% of staff are being re-educated on the policy and expectation that incident reports are to be completed for any unusual occurrence that is outside of the normal course of the patient's admission, care, and discharge. Staff are to complete the training prior to their next scheduled shift. B) Policy 1800.21 Room Searches was reviewed by the Hospital Leadership and updated to include notifying the Risk Manager of contraband and conducting a RCA. 100% of staff are being re-educated on the policy. Staff are to complete the training prior to their next scheduled shift. V 366 continued below	12/06/2019

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V 366	Continued From page 18 (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 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;	V 366	(V366 continued from prior page) **C)The Director of Compliance/Quality/Risk/ and assistant were re-educated by the CEO on the expectation that all unusual occurrences are to be investigated fully, documented and reported internally and external to the Hospital, as required.** **2) The procedure for implementing the acceptable plan of correction for the specific deficiency cited** A)100% of staff will be retrained on the Completion of Incident Reports policy and on the updated Room Search policy. B)A new form will be created to ensure room searches are being conducted per policy and the RN assigned to each unit will sign off on this form. **3) The monitoring procedure to ensure that the plan of correction is effective, and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements** A)Daily in the Morning Meeting of Hospital Leadership, 100% of incident reports received will be reviewed against the total number of unusual occurrences to ensure that a report was received for each occurrence. The DCQR will label each incident as I, II, or III using the North Carolina regulatory requirements. B)The CEO will follow up with each level II or III incident to ensure it was investigated thoroughly through hospital processes and reported as required. C)Room search forms will be brought to each Safety Committee Meeting for review and discussion of findings. D) Results of these audits will be reported into the Morning Meeting of Hospital Leadership, monthly Quality Council and MEC, and quarterly Governing Board at each of their respective meetings. This process will remain at 100% review frequency on a go forward basis. (V366 continued on next page)	

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V 366	Continued From page 19 (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 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.	V 366	(V366 continued from prior page) **4) The title of the person responsible for implementing the acceptable plan of correction.** Director of Compliance/Quality/Risk Report continues on Page 26	

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This Rule is not met as evidenced by:
Based on record reviews and interviews the facility failed to document their response to a level I and II incidents. The findings are:

Review on 10/9/19 of internal investigations between 8/2/19 and 10/9/19 revealed:
-There were no internal investigations for any clients self tattooing.
-There was no internal investigation of lancets taken by client #1 and given to his peers to self tattoo.

Review of incident reports on 10/9/19 and 10/15/19 between 8/2/19 and 10/9/19 revealed:
-"Health Incident Review Report," dated/timed 8/16/19 at 9:45 am, documented a staff member had been stuck with a sharp object (lancet) found in a client's comfort box. The client's name was not documented in the report.
-Level 1 incident report, dated 8/19/19, documented client #7 had self inflicted a tattoo to his left forearm. It was documented client #7 "apparently" became upset when told this would be reported and he hit the wall with his right hand. A sharp object was obtained. Treatment given included first aid (arm cleansed with soap, water, alcohol), and a X-ray ordered.

Review on 10/15/19 of "Carolina Dunes Behavioral Center Room Check" and "... Midnight Floor Census" forms between 8/16/19 and 8/21/19 revealed:
-Room searches on 8/16/19, 8/19/19, and 8/21/19 documented contraband was found in 10 client rooms that could be used for self tattooing.
-Contraband documented included needles and

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V 366	Continued From page 21 lancets in rooms 401 on 8/16/19, room 400 on 8/19/19, and rooms 403 and 405 on 8/21/19. -Other contraband documented that could be used for tattooing included pens, ink, cards, wires, paper clips, and staples. -Client #7 was in room 400, client #8 was in room 303, and client #1 was in room 404. Review on 10/15/19 of Safety Committee documentation between 8/16/19 and 8/21/19 revealed -8/20/19 Safety Committee review of incidents documented client #7 "SIB (self-injurious behavior)/contraband, scratched (tattoo) in L (left) forearm, hit wall w/R (with right) hand, slight swell/bruise 4th and 5th digit... No documentation the client used a lancet or actions to follow up client #7's use/possession of contaminated lancets. -No documentation of discussions or investigations of contraband found in clients' rooms that could be used for self tattooing, to include contaminated lancets/needles. Interview on 10/14/19 client #1 stated: -Some of the nurses would let him check his blood sugar (BS). After checking his BS he would lay the lancet on the cart, then pick it back up when the nurse was not watching. There was no receptacle to dispose of used lancets. -There was a point in time he would save the needles for his peers to "stick and poke," which meant they would use the needles to make tattoos. -He took about 7 needles and gave them to client #3, client #6, client #12, and discharged client #17. -He (client #1) did not do any tattooing. -Staff did a search and found other needles and they continued to let him check his BS without a	V 366		

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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 366	Continued From page 22 receptacle to dispose of the used lancets. Review on 10/15/19 of client #3's record revealed he was treated on 8/19/19 for using contaminated lancet to self tattoo. Client #3 was treated with intramuscular injection and topical antibiotics. Interview on 10/15/19 client #3 stated he obtained needles from other clients known to check their blood sugar. Ink for the tattoos was obtained using gaming cards. He acquired alcohol pads from the staff to disinfect the needles. Review on 10/15/19 of client #7's record revealed he was treated on 8/19/19 for using contaminated lancets and a pen spring & ink to self tattoo. Client #7 was treated with oral and topical antibiotics. Interview on 10/15/19 client #7 stated he got the lancet from client #1 and the ink pen from a peer. A room search was done about 4-5 days after he was treated by the physician and the lancet was found in his room. He had the lancet in his comfort box about 5 or 6 days before it was found. Review on 10/15/19 of client #8's record revealed he was treated on 8/19/19 for using contaminated lancets to self tattoo. Client #8 was treated with an intramuscular injection, oral, and topical antibiotics. Interview on 10/15/19 client #8 stated he had been tattooing his arm for a week before it was identified by a nurse. He used a needle he got from client #3, who had gotten it from a peer who did blood sugar checks. Interview on 10/9/19 the Director of Compliance/Quality/Risk/Risk	V 366		

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	MHH0976	A. BUILDING: _____ B. WING _____	10/15/2019

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V 366	Continued From page 23 Management (Q/RM) stated: -It had been identified on 8/16/19 that client #1 had taken a lancet after checking his BS. This was identified when a staff was stuck by a lancet found in client #1's comfort box. Client #1 was questioned and he gave a nurse's name. The named nurse denied this happened when interviewed. -There had been no internal investigations of clients self tattooing with contaminated lancets because this had not been reported. Interview on 10/15/19 the Director of Nursing stated: -She was not able to identify clients who had been treated for self tattooing using contaminated lancets. -She would have to look at incident reports with the Director of Q/RM to identify any such clients. Continued interview on 10/15/19 the Director of Q/RM stated: -She was able to find one level 1 incident report that identified client #7 had self tattooed. (Incident report dated 8/19/19). -The Quality/Risk Specialist completed a level 1 for client #7. He did not consider this to be a level II because it did not go beyond first aid. -All incident reports go to the Safety Committee daily. -The MHTs (Mental Health Technicians) did the room searches as a daily routine. Not sure if there was a report of what was found during these searches.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR	V 367	V367 begins on next page	

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V 367	Continued From page 24 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 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:	V 367	V367 begins **1)The plan for correcting the specific deficiency cited** The DCQR will be re-educated on requirements related to reporting to the LME. **2) The procedure for implementing the acceptable plan of correction for the specific deficiency cited** A) The DCQR will be re-educated, and then will re-educate those with reporting responsibilities, through IRIS manual review and memorandum, on the requirement that level II and level III incidents will be documented in the IRIS system within 72 hours after each occurrence. B)The DCQR will present information on any level II or level III incident, based on IRIS reporting requirements to the CEO on a M-F basis. The DCQR shall present evidence to the CEO that the report has been made no later than 72 hours after the occurrence by comparing and showing the date/time the hospital was made aware of the incident to the date/time the report was made. The DCQR will document that this review has occurred. Compliance with this requirement will be addressed through the progressive disciplinary action process. C)The DCQR will utilize all reporting methods to include fax, phone, and/or emails to ensure compliance. **3) The monitoring procedure to ensure that the plan of correction is effective, and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements** A)The DCQR will present information on any level II or level III incident to the CEO on a M-F basis. The DCQR shall present evidence to the CEO that the report has been made no later than 72 hours after the hospital became aware of the incident by comparing and showing the date/time the hospital was made aware of the incident to the date/time the report was made. B)Evidence of the DCQR's compliance with reporting requirements will be reported daily in the Hospital's Morning meeting. V367 continued below	November 14, 2019

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V 367	Continued From page 25 (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 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.	V 367	V367 continued The findings, conclusions, recommendations, and actions taken will be aggregated and forwarded by the DCQR to the Hospital's Quality Council, MEC, and Governing Board at each of their respective meetings. This review and reporting process will continue on a go forward basis. **4) The title of the person responsible for implementing the acceptable plan of correction.** The Director of Compliance/Quality/Risk (DCQR) (Report response continues on page 30)	

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V 367	Continued From page 26 This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to submit Level II incident reports as required. The findings are: Review on 10/9/19 of an internal investigation for an incident on 10/3/19 revealed: -10/3/19 client #4 and client #9, together, eloped from a facility outing around 12:45 pm. The police were notified and found the 2 clients at a local store 3 hours later at 3:45 pm. -Client #9 made an allegation she had been sexually assaulted during the elopement and was seen in the emergency room and had a rape kit performed. Review on 10/9/19 of an internal investigation for an incident on 9/21/19 revealed client #5 was transported to the emergency room following a suicide attempt. Review on 10/14/19 of North Carolina Incident Response Improvement System (IRIS) reports between 8/2/19 and 10/9/19 revealed: -No IRIS report for client #4's elopement on 10/3/19. -IRIS report for client #9's elopement and allegation of sexual assault on 10/3/10 was originally submitted on 10/14/19. -Client #5's suicide attempt on 9/21/19 originally submitted on 10/14/19.. -No IRIS reports for client #3, client #7, or client #8's self tattooing with contaminated lancets. -No IRIS report for client #1 giving his contaminated lancets to peers for self tattooing. Interviews on 10/14/19 the Director of	V 367		

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V 367	Continued From page 27 Quality/Risk Management stated: -She had a new staff submitting IRIS reports. There had been some difficulties experienced with submitting the IRIS reports. -She did not have a level II IRIS report for client #4's elopement. -She provided an IRIS report with "Date Last Submitted: 10/14/19" for client #9's elopement. -She provided an IRIS report for client #5's suicide attempt "Date Last Submitted: 1/1/1001." -There were no other level II IRIS reports for time period requested by survey team (requested reports on 10/9/19 between 8/2/19 and 10/9/19). Refer to V366 and V314 for additional information.	V 367		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are: Observations of the facility on 10/10/19 at approximately 9:20am revealed: -Room #102 had wood laminate on the side of the bathroom sink separated at the bottom on the left side. A3 foot (ft) long stained area in carpet	V 736	**A. The processes that led to the deficiency cited** The facility was not maintained in a clean, attractive and orderly manner and shall be kept free from offensive odor. **B. The procedure for implementing the acceptable plan of correction for the specific deficiency cited;** The facility has filled all housekeeping vacancies to address all needs on every unit. SBC will also be contracting with an outside cleaning service to perform industrial cleaning on a periodic basis. V736 continued below	

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V 736	Continued From page 28 was observed in front of the bathroom. -Room #103 had multiple long yellow streaks down the wall behind the entrance door. The word F**K was written on the left side of the wall beside the bed. -Room #104 had wood laminate board loose at top and hanging off side of the sink. -Room #105 had wood laminate peeling from the bottom of the bathroom sink. The desk under the window was missing Formica covering on top and on both side panels. -Room #106 had a 2 1/2 foot area of wall plastered beside toilet with white paint around it and a 1 ft x 1 ft hole in the wall beside the bathroom sink. -Room #108 had multiple cracks in the molding on the floor by the shower. -Room #201 had Formica missing from side of the desk by the bathroom. Multiple 1 inch (in) and 1/2 in. spots of toothpaste were smeared on the left side of the wall. -Room #202 had a 4 ft long and 3 foot wide crescent shaped stain in the carpet at the entrance of the bathroom. -Room #204 had Formica missing around the top of the desk and on the top and bottom of the right side of the sink in the bathroom. -Room #207 had laminate flooring ripped on floor and off the wall by the toilet. -Room # 302 had white debris across the floor and damaged drywall in the bathroom. Damaged drywall was approximately 10 inches in width and 7 foot in height behind the bathroom door. A second area of drywall damage was observed to the right of the toilet, approximately 24 inches by 24 inches in size. Room # 304 had a patched wall behind the bathroom door, approximately 12 inches by 24 inches in size. -Room #307 had a patched wall to the right of the	V 736	***C. The monitoring procedure to ensure that the plan of correction is effective, and that specific deficiency cited remains corrected;*** The EOC Director (or designee) will perform weekly checks of each unit to ensure cleanliness of the facility. Findings will be reporting to Morning Meeting Leadership meetings, monthly Quality Council meetings, and quarterly Governing Board. ***D. The title of the person responsible for implementing the acceptable plan of correction.*** EOC Director	

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V 736	Continued From page 29 bathroom sink, approximately 8 inches by 8 inches in size. -Room #309 was missing the right side faucet handle in shower. -Room #403 had drywall damage behind bedroom door, approximately 36 inches in height and 4 inches in width. -Room #405 had strong smell of urine when entering bathroom and section of laminate from counter top missing to right side of bathroom counter. Section was approximately 16 inches in length. In addition, bathroom counter molding was missing leaving exposure of approximately 26 inches by 24 inches around countertop. -Room #404 had a baseball size hole in the bathroom wall behind the toilet. White debris was observed throughout on floor. -Room #407 had drywall damage approximately 24 inches by 26 inches in size. -Room #409 had a strip of laminate missing on bathroom counter, approximately 10 inches in length. -Room 408 had fecal matter on bottom of toilet seat in bathroom. Interview on 10/10/19 the Environment of Care Director stated: -The facility had been in the process of removing carpet and replacing with vinyl flooring in all the clients rooms. -He was not aware of the wood laminate hanging off on the side of the bathroom sink in room #104. -The yellow stains on the wall in room #103 was macaroni and cheese. -Bathroom had flooded in room #102. -Clients sometimes used the toothpaste to hang stuff on the walls. [This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.]	V 736		

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