STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20140058	A. BUILDING: _____ B. WING _____	C 11/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVORIAL CENTER	3200 WATERFIELD DRIVE GARNER, NC 27529

(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 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	*Please note that Strategic Behavioral Center – Raleigh takes these findings seriously and is fully committed towards developing effective strategies for compliance with regulations and monitoring and evaluation activities to ensure compliance with same.* *Pursuant to your request, the corrective actions are delineated in the following pattern:* *a) The procedure for preventing the deficiency and implementing the acceptable plan of correction for the specific deficiency identified;* *b) The date by which all corrective actions will be completed, and the monitoring system will be in place.* *c) The monitoring procedure to ensure that the plan of correction is effective, and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements.* *d) The title of the person responsible for implementing the acceptable plan of correction* **A) The procedure for preventing the deficiency and implementing the acceptable plan of correction for the specific deficiency identified:** The DQCR has been re-educated on requirements related to reporting to include a review of Strategic' s policies on reporting as well as the regulatory requirements. as delineated in, G.S. 108A Article 6, G.S. 7B Article 3 and 10A NCAC 27G .0604. ***C) The monitoring procedure to ensure that the plan of correction is effective, and that specific deficiency cited remains corrected;*** Evidence of the DQCR's compliance with reporting requirements will be reported weekly in the Hospital's Morning Meeting. The findings, conclusions, recommendations, and actions taken will be aggregated and forwarded by the Director of Quality/Compliance/ Risk to the Hospital's monthly Quality/PI Council, Medical Executive Committee and quarterly Governing Board at each of their respective meetings. This process will continue as presented on a go-forward basis and has no end date.	b)11.16.19
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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V 367	Continued From page 1 missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet	V 367	A summary of the findings is being forwarded to the Morning meeting of Hospital Leadership Monday through Friday, the monthly Quality/PI Council, the monthly Medical Executive Committee and the Governing Board at each of their respective meetings. The findings from the review will be continued at the Morning Meeting for a period of 3 months, and, if at 98% and above, the results will be reduced to a review at the monthly Quality/PI Council Meeting. **Responsible person**: **D)** Director of Compliance/Quality/Risk V 367 Ends	

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V 367	Continued From page 2 the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record 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: Review on 11/12/19 of Client #4's record revealed: - admission date: 5/24/19 - diagnoses of Post Traumatic Stress Disorder, Mood Disorder, Vitamin D deficiency, Constipation and Insomnia - documentation from a "Judicial Appeal" dated 10/3/19 with documentation that Client #4: - has had an increase in the frequency and severity of his outbursts and aggression. - saw dominance as a motivation to fight - had episodes of running up and down the halls, yelling during relaxation time - a behavior plan dated 5/24/19 documenting Client #4 utilized walking up and down the halls to help calm himself	V 367		

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V 367	Continued From page 3 During an interview on 11/12/19 MHT#1 (Mental Health Technician) reported: - the 500 unit hallway carpet was being replaced with hardwood floors - clients were relocated to the cafeteria - client #4 refused to be in the cafeteria with the group - he left out of the cafeteria to the hallway in front of the cafeteria - she followed him to redirect him back to the cafeteria - MW#1 (maintenance worker) was in the hallway working - MW#1 stood between her and client #4 - MW#1 said client #4 was being unsafe pacing up and down the hallway - client #4 did not say anything but continued to pace - she told client #4 to calm down and talk with her so they could find a solution - client #4 asked how he was being unsafe - DRNC (Disability Rights of North Carolina) came down the hallway - DRNC & MW#1 had words - MW#1 left the hallway - client #4 left with the Patient Advocate During an interview on 11/13/19, MW#1 reported: - 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 - 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 - 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	V 367		

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V 367	Continued From page 4 because he was the person who replaced the doors. - 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. - Client #4 was cursing at him calling him a "f____g old man" - 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. During an interview on 11/13/19 Client #4 reported: -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.) - 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" - he did not say anything to MW#1	V 367		

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V 367	Continued From page 5 - acknowledged he had previously broken doors on the units when he was mad - that day he only wanted to speak with the DRNC worker who had just walked onto the hall During an interview on 11/13/19, Client #4's Clinician reported: - he was involved in the meeting after the incident occurred - Client #4 has frequently kicked in the metal doors on the halls in the facility - Client #4 frequently misinterpreted other's actions and words During an interview on 11/12/19, the Director of Compliance and Risk Management (DOC/RM) reported: - 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." - 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 - there was no documentation of this meeting	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		

STRATEGIC
BEHAVIORAL CENTER

January 24, 2020

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
C/O Rhonda Smith
2718 Mail Service Center
Raleigh, NC 27699-2718

RE: POC Complaint Survey completed November 13, 2019. Intake #NC00156578.

Dear Ms. Smith:

Please see the attached Plan of Correction I am submitting on behalf of Strategic Behavioral Center-Garner. We would like to ensure you that we are dedicated to providing quality care for patients. We appreciate the courtesy extended to us during this survey.

Respectfully,

Rachel Beal

Rachel Beal, CEO

Enc: Plan of Correction

qsj

3200 Waterfield Drive ◆ Garner, North Carolina 27529
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