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 _____	04/14/2020

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 survey was completed on April 14, 2020. One complaint was substantiated (intake #NC00160793) and two complaints were unsubstantiated (intake #NC00161385 and #NC00162006). A deficiency was 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 Health (CDBH) 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. Pursuant to your request, the response is structured as follows:* *1)The plan for correcting the specific deficiency cited. The processes that led to the 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 (POC) 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*	
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and	V 105	**1) The plan for correcting the specific deficiency cited** A. All nursing staff were re-educated through an in-service on the expectations that all serious occurrences are reported via an Incident Report to Risk Management, including fractures that are diagnosed outside of the facility. B. 2. Nursing staff were trained to scan all x-ray findings to risk management for further review and investigation **2) The procedure for implements the acceptable plan of correction for the specific deficiency cited** A. All nursing staff were re-educated through an in-service on the expectations that all serious occurrences are reported via an Incident Report to Risk Management, including fractures that are diagnosed outside of the facility. **3) The monitoring procedure for implementing the acceptable plan of correction** A. Risk management will compare all positive findings of x-rays with incident reports to ensure events are properly reported. B. All incidents will be reviewed during the Hospital's Morning Meeting M-F with Fri, Sat, and Sun results incorporated into Monday's report. **4) The title of the person responsible for implementing the acceptable plan of correction** A. Quality Risk Director	May 1, 2020

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

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V 105	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure serious occurrences were reported to the Protection and Advocacy system as required. The findings are: Per the Code of Federal Regulations (CFR) 483.374(b), "the facility must report to both the State Medicaid agency and the Protection and Advocacy system (Disability Rights of North Carolina (DRNC)) no later than close of business the next business day after each serious occurrence. Reportable serious occurrences include...c. A resident's suicide attempt...Staff must document that each serious occurrence was reported to both the state Medicaid agency and the state designated Projection and Advocacy system." Review on 04/02/20 of Former Client (FC) #5's record revealed: - 13 year old female. - Admission date of 12/05/19. - Diagnosis of Bipolar Disorder, Unspecified. - Discharge date of 02/15/20. Review on 04/02/20 of a facility "Investigation Reporting Form" for FC #5 revealed: - Date of Incident: 01/14/19. - "Description of the Incident: Patient first complained of pain in hand on 1/15/20 after hitting it on the wall while dancing. Nurseed placed IM (Internal Medicine) consult on 1/15/20. Provider examined patient on 1/16/20 and ordered x-ray. X-ray was take on 1/17/20 and findings were negative for any fractures. Internal Medicine provider continued to follow-up patient and complained of pain again on 1/21/20. Order	V 105		

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V 105	Continued From page 3 was written to be evaluated by Emerg Ortho on 1/22/20 and was seen the same day. A 2nd x-ray was completed indicating a proximal phalanx fracture of left thumb. Patient was placed in cast and is to follow up in 4 weeks for recheck." - No documentation DRNC was notified no later than close of business the next business day after the fracture was identified. Review on 04/02/20 of a North Carolina Incident Response Improvement System report for FC #5 revealed: - Date of Incident: 01/14/20. - Provider Comments: "Patient first complained of pain in hand on 1/15/2020 after hitting it on the wall while dancing. Nursed placed IM consult on 1/15/2020. Provider examined patient on 1/16/2020 and ordered x-ray. X-ray was taken on 1/17/2020 and findings were negative for any fractures. Internal Medicine provider continued to follow-up patient and complained of pain again on 1/21/2020. Order was written to be evaluated by Emerg Ortho on 1/22/2020 and was seen the same day. A 2nd x-ray was completed indicating a proximal phalanx fracture of left thumb. Patient was placed in cast and is to follow up in 4 weeks for recheck." - No documentation DRNC was notified no later than close of business the next business day after the fracture was identified. Interview on 04/14/20 the Risk Management Coordinator stated: - He was informed DRNC was notified of FC#5's fracture on 01/30/20. - He was now aware DRNC should be notified no later than close of business the next business day after each serious occurrence. - He would follow up with his supervisor.	V 105		