Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ___ B. WING _____	(X3) DATE SURVEY COMPLETED
	20140058		C 05/26/2020

NAME OF PROVIDER OR SUPPLIER
STRATEGIC BEHAVORIAL CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
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 05/26/20. The complaints were substantiated (Intake #NC164351, #NC164336, #NC164359, #NC164141, #NC163914, #NC165677, #NC162370) and unsubstantiated (Intake #NC162008). Deficiencies were cited. This facility is licensed in the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment 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*	b) facility wide training 4/19-20/2020 &4/28-4/30/2020 Nursing monthly meeting 5/1-5/8, 2020 Environmental Awareness & Zoning training 5/21-5/27/2020 2:6 Ratio & Level of Observation Training 5/15-5/18/2020 education on magnetic keycard 5/16/2020 ordered wristbands 5/18/2020 distributed wristbands to staff 5/29/2020 received proposal from BFPE to install the keypad the first week of July
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 specializedinterventions on a 24-hour basis. (d) Therapeutic interventions shall address functional deficits associated with the child or adolescent's diagnosis and include psychiatric 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.	V 314	*V314 starts here* **A. Elopement on the roof** *A)* Plan for preventing the deficiency A root cause analysis was held with the Hospital Leadership, a Governing Board (GB) representative and staff involved about this incident and the contributing factor to this event identified as follows: (1) At the time of the event, the unit census was 11 and there were 3 MHTs and 1 RN assigned. However, staff were allowed to split into different areas, inconsistent with the 2:6 ratio: only one was in the courtyard. There should have been at least 2 direct care staff and no more than 6 patients. At the time of the incident 1 MHT was allowed to be outside supervising 10 patients. (2) Patient was able to prop his feet on a door to a water valve and hold the gutter to pull himself onto the roof with the assistance of one of his peers boosting him to the roof. A Plan of Action was, subsequently developed as follows. (1) Reeducate all nursing staff on 2:6 Ratio Management, "Zoning" Patients (i.e., staying close and positioning yourself strategically). Policies 1300.31, Elopement Precautions, and 1300.17 Elopement, Handoff Communication & Patient History of At-Risk Behavior.	

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V 314	Continued From page 1 (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 review and interview, the facility failed to provide a structured living environment for children who required supervision and specialized interventions on a 24-hour basis. This affected 7 of 11 audited clients (#702, #594, #673, #704, #621, #709 and #725). The findings are: Cross reference: 10A NCAC 27G.1902 Psychiatric Residential Treatment Facility for Children and Adolescents- Staff (V315). Based on record review and interview, the facility failed to meet minimum staffing requirements. A. Elopement on the roof Review on 05/07/20 of client #702's record	V 314	(2) The importance of adhering to schedule. (3) Refresher training on walkie talkie process (4) Education on reporting lost keys. (5) Nursing monthly meeting regarding MHTs zoning. (6) The water valve door was properly secured to prohibit patients accessed. C) The monitoring procedure to ensure that the plan of correction is effective. (1) To ensure compliance, 100% of the PRTF unit staffing is being monitored by the Milieu Managers & House Supervisors as they conduct headcount of assigned staff. This process is being performed daily. (2) Daily reporting of staffing is discussed in morning meetings with hospital leadership any issues are resolved immediately. (3) FTE meeting is held daily (M-F) with the CFO, CEO, Nursing Management to troubleshoot any staffing issues. (4) The Environment of Care Director conducts 100% safety rounds of the facility to include the courtyard. A summary of the findings is being forwarded to the Morning Meeting of Hospital Leadership Monday-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. D.) Title of person responsible for implementing the appropriate plan of correction. Interim DON & EOC Director	

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V 314	Continued From page 2 revealed the following: -Admitted: 02/26/20 -Diagnosis: Major Depressive Disorder -Treatment plan dated 09/17/19 last updated 04/07/20 - Goals inclusive of adhere to Psychiatric Residential Treatment Facilty for Children rules as evidence of zero incidents of running away. He self reported his initial response to triggers and frustration is to "take space: however, if he does not feel is he able to calm himself quickly, he will run away (which has been the case numerous times in the past)." -Age: 15 Review on 05/11/20 of the facility's internal investigation report revealed the following occurred on 03/28/20: -Around 11:51 AM, client #702 was escorted from the residential hallway to the courtyard by (Mental Health Techinician) MHT #2. -Around 11:53 AM, MHT #1 outside in courtyard with 9 clients. MHT #2 left the courtyard which left MHT #1 in the courtyard with 10 clients. MHT #3 was inside the facility and assisted client #594 to make a telephone call -Around 11:57 AM, MHT #3 opened the door to the courtyard as client #594 had completed his phone call. Client #594 went outside in the courtyard. Inside the facility, MHT #3 picked up a football, gave it to someone in the courtyard and re-entered the residential hall. -Around 11:59 AM, the clients in the courtyard banged on the window to get attention of the nursing and MHT staff (#3, #2) on the hallway inside the facility. -While in the courtyard, client #702 used the metal pieces that secured the gutter to the building to climb up on the roof of the facility. He eloped from the facility. He was found by the police around 1:07 PM.	V 314	B. Elopement with found badge in hallway Plan for preventing the deficiency A root cause analysis was held with the Hospital Leadership, a Governing Board (GB) representative and staff involved about this incident and the contributing factors to this event identified as follows. (1) Proper handoff communication did not occur. (2) Unit schedule was not adhered to. (3) assigned direct care staff were not managed appropriately to maintain the 2:6 ratio. (4) Not all staff had a walkie-talkies (5) A lost key card was not reported, as required. Patient found it and it used to elope. A Plan of Action was, subsequently developed as follows. (1) Reeducate all nursing staff on 2:6 Ratio Management, "Zoning" Patients (i.e., staying close and positioning yourself strategically). (2) Reeducate staff on proper handoff communication (3) Reeducate staff on adherence to program schedule (4) Reeducate staff on reporting of lost keys (5) Reeducate staff on having walkie talkies C) The monitoring procedure to ensure that the plan of correction is effective. (1) To ensure compliance, 100% of the PRTF unit staffing is being monitored by the Milieu Managers & House Supervisors as they conduct headcount of assigned staff. This process is being performed daily. (2) Daily reporting of staffing is discussed in morning meetings with hospital leadership any issues are addressed immediately, (3) 100% daily monitoring of walkie talkies by Milieu Managers & Charge Nurse A summary of the findings is being forwarded to the Morning Meeting of Hospital Leadership Monday-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.	b) facility wide training 4/19-20/2020 on 2:6 ratio memo &4/28-4/30/2020 Nursing monthly meeting 5/1-5/8, 2020 Environmental Awareness & Zoning training 5/21-5/27/2020 2:6 Ratio & Level of Observation Training

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V 314	Continued From page 3 -Client #673 attempted to climb onto the roof. MHT #3 intervened to prevent client #673 from access to the roof. During interview on 05/07/20, client #702 reported the following regarding the 03/28/20 elopement: -He was upset because he was not allowed to use the phone, so he eloped -While in courtyard, he told client #673 of his elopement plan -The gutters had metal pieces around them, to prevent people from pulling it down. He used the metal pieces to step and lift himself from the ground to the roof. -He was not sure what staff were doing, how many staff were outside nor how many clients were in the courtyard at the time of his elopement. During interview on 05/07/20, MHT #1 reported the following: -In the enclosed courtyard, some of the clients wanted to walk laps and the others wanted to sit on a bench -At the time of the incident, he was across the courtyard talking with a group of clients who were on the bench. Most of the clients on the bench had a history ofaggression. -He "looked back and [client #702] was on the roof. I initially thought [client #673] boosted him on the roof. Later during the investigation, it was discovered he did not." -MHTs #2 and #3 were inside the facility at the time of the elopement. B. Elopement with found badge in hallway Review on 05/07/20 of client #594's record revealed the following: -Admitted: 03/13/20	V 314	D) Title of person responsible for implementing the appropriate plan of correction. Interim DON Allegation of sexual assault against alleged Perpetrator who had specialized supervision orders A root cause analysis was held with the Hospital Leadership, a Governing Board (GB) representative and staff involved about this incident and the contributing factor to this event identified as follows. (1) Proper handoff communication did not occur (2) Level of observation policy for 1:1 was not followed (3) 2:6 ratio was not followed. Per the unit census at the time. A Plan of Action was, subsequently developed as follows. (1) Reeducate all nursing staff on 2:6 Ratio Management, "Zoning" Patients (i.e., staying close and positioning yourself strategically) (2) Reeducate staff on Handoff Communication & Patient History of At-Risk Behavior. (3) Reeducate staff on Level of Observation policy (4) Reeducate staff on Environmental Awareness, Effective Communication & Zoning the units C) The monitoring procedure to ensure that the plan of correction is effective. (1) To ensure compliance, 100% of the PRTF Levels of Observation are being monitored daily to ensure appropriate monitoring. This audit includes a 100% review of all physicians' orders, the assignment sheets, and the level of observation flowsheets to ensure appropriate monitoring. (2) Daily reporting of staffing is discussed in morning meetings with hospital leadership any issues are trouble shoot immediately, (3) 100% of the PRTF unit staffing is being monitored by the Milieu Managers & House Supervisors as they conduct headcount of assigned staff. This process is being performed daily (4) The AOC collaborates daily with the House Supervisor (HS) and conduct daily audits to check ratios and address immediately by reallocating staff as necessary with the CEOs authority.	b) facility wide training 4/19-20/2020 &4/28-4/30/2020 Nursing monthly meeting 5/1-5/8, 2020 Environmental Awareness & Zoning training 5/21-5/27/2020 2:6 Ratio & Level of Observation Training

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V 314	Continued From page 4 -Diagnoses: Post Traumatic Stress Disorder, Disruptive Mood Dysregulation Disorder, Conduct Disorder, Cannabis Disorder and Obsessive Compulsive Disorder -Treatment plan dated 02/25/20 last updated 03/20/20 noted behaviors in 2020 included physical/verbal aggression, runaways, robbery, gun theft and possession of stolen cars. Goals inclusive of adhere to treatment, increase communication to reduce behaviors, develop coping skills to reduce drug use and increase decision making skills to reduce episodes of eloping. -Age: 15 During interview on 05/01/20, the Director of Compliance and Risk Management (DOC/RM) reported: -This location was a secure facility. -Key cards were utilized to unlock doors throughout the building -Each staff was issued a badge and a key card. Review on 05/11/20 of the facility's internal investigation report revealed the following occurred on 04/13/20 on the 700 residential hall: -While transported from the education hallway to their residential hallway earlier in the day, clients #702 and #594 found a key card on the floor. Clients were able to hide that key card from staff. -Around 9:30 PM, with MHTs #4 and #5 in the hallway, clients #702 and #594 used the key card found earlier in the day to open the doors to escape out of the facility. -Clients #702 and #594 were secured by the police five hours later at a gas station. During interview on 05/07/20, client #594 reported	V 314	A summary of the findings is being forwarded to the Morning Meeting of Hospital Leadership Monday-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. D) Title of person responsible for implementing the appropriate plan of correction. Interim DON, DQCR C) Elopement using staff badge Plan for preventing the deficiency An internal investigation was completed by the Risk Management Department, and the contributing factor to this event identified as follows: (1) The 2:6 ratio was not being adhered to during the transitioning of the patients (2) Patient snatched the staff badge from around her neck and eloped from the facility A Plan of Action was, subsequently developed as follows. - (1) reeducate all nursing staff on 2:6 Ratio Management, "Zoning" Patients (i.e., maintaining ratio always including during transitioning) (2) Education to staff regarding removing the magnetic key card from their badge (3) Consultation with BFPE regarding installing a keypad to enter the lobby and not the key card (4) Ordering wristbands for staff to place their magnetic key card in vs having them around their neck C) The monitoring procedure to ensure that the plan of correction is effective. (1) Daily reporting of staffing is discussed in morning meetings with hospital leadership any issues are addressed immediately, (2) 100% of the PRTF unit staffing is being monitored by the Milieu Managers & House Supervisors as they conduct headcount of assigned staff. This process is being performed daily	b) facility wide training 4/19-20/2020 &4/28-4/30/2020 Nursing monthly meeting 5/1-5/8, 2020 Environmental Awareness & Zoning training 5/21-5/27/2020 2:6 Ratio & Level of Observation Training 5/15-5/18/2020 education on magnetic keycard 5/16/2020 ordered wristbands 5/18/2020 distributed wristbands to staff 5/29/2020 received proposal from BFPE to install the keypad the first week of July

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V 314	Continued From page 5 the following events from 04/13/20: -He and client #702 were speed walking ahead of group as his hall was being escorted to their residential hall. Two staff should have assisted transporting groups from one area to the next. The transport should have reflected one staff in front, one staff in the back and maybe a third staff in the middle if it was the entire hall being transported. -On this day, one staff was distracted and redirected some clients that were midway the single line. The second staff was at the end of the line. -He saw the key card on the floor on the administrative hallway. He bent down like he was fixing his shoes. He put the key card in his pocket. -At 9:30 PM, "we beeped out of the hall." He used the badge to gain access from their residential hall to the front door of the facility. "We went to [bordering county]. We started searching cars for money... I had $6 when I opened up the car. [Client #702] saw a man and asked if he could give us a ride to the store. The man gave me a pair of shoes..... The man smelled like weed so he gave us the weed, I asked him for the weed... I asked to use his phone to call my mom and my brother.... I called my brother first (I don't know the time). I called my mom at midnight...this man gave us a ride to [nearby city]. At the store, we saw cops and they(cops) started running. They (cops) saw [Client #702] and then me. They (cops) threw the weed away." He estimated, he returned to the facility at 2:30 AM. During interview on 05/07/20, MHT #4 reported the following events from the night of 04/13/20: -Bedtime for clients was 9:00 PM -One client had difficulty as he had been transferred from another residential hall. This	V 314	(3) The AOC collaborates daily with the House Supervisor (HS) and conduct daily audits to check ratios and address immediately by reallocating staff as necessary with the CEOs authority. A summary of the findings is being forwarded to the Morning Meeting of Hospital Leadership Monday-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 D) Title of person responsible for implementing the appropriate plan of correction. Interim DON, CFO V314 ends here	

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V 314	Continued From page 6 client did not want to be on this hall and wanted to return to his previous hall. MHT #4 allowed this client to stay up 30 minutes to vent about the situation. This client agreed to the 9:30 PM bedtime and sat right beside MHT #4. -Client #594 also came and sat beside MHT #4. MHT #4 reiterated the 9:30 PM bedtime. MHT #4 thought it was a normal conversation, "nothing out of the ordinary." Client #594 had on shoes which was okay for a common area at the facility. Neither of these clients had on a jacket -At 9:28 PM, he and MHT #5 redirected the clients towards their bedrooms. Client #702 ran from his bedroom, down the hallway toward client #594. Client #702 had on his shoes and jacket. Both clients ran toward the keypad and went out the main hallway of the building. "People were in the hallway but it happened quickly. I ran after them." During interview on 05/08/20, the Admission and Intake staff reported: -Her duties included admission and assessments. She worked in the front near the reception office and assigned badges and key cards to visitors. -The morning of 04/13/20, she was asked about her key card. -She had not noticed her badge and key card were missing. She would utilize the key card of co-workers if needed to gain access throughout the building. -At the time of the incident, she did not keep her key card around her neck or within eyesight. "I just got too comfortable." -After the 04/13/20 incident, she was trained on how to secure the badge and key card and report if misplaced C. Allegation of sexual assault against alleged	V 314		

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V 314	Continued From page 7 perpetrator who had specialized supervision orders. Review on 05/19/20 of client #704's record revealed: -Admitted: 03/31/20 -Diagnoses: Oppositional Defiant Disorder and Attention Deficit Disorder -History of making sexual assault allegations -Age: 12 Review on 05/19/20 of client #621's record revealed: -Admitted: 11/21/19 -Diagnoses: Bipolar -History of being accused of sexualized behaviors -Physician's orders between 03/17/20 and 05/03/20 listed 1:1 observations at all times either due to sexualized or unsafe behaviors. -Age: 14 Review on 05/11/20 of internal investigation report revealed the following occurred on 05/03/20 on the 600 hallway: -Clients #704 and #621 were roommates. -Client #704 alleged between 7:30-9:00 PM, his roommate (client #621) performed both oral and anal sex on him while they were in their bedroom alone. He did not tell staff until 05/04/20. -Video log timeline supported evidence client #621 did not have an assigned 1:1 staff. He was observed for frequent but limited time periods (10 -60 seconds) coming in and out of his bedroom. Video supported two intervals when both clients were in their room without staff for over one minute (8:08:30 to 8:09:50....8:13:42 to 8:16:01). Review on 05/18/20 of the staff assignment sheet dated 05/03/20 revealed between 7:30 PM-7:00	V 314		

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V 314	Continued From page 8 AM "all staff" designated as 1:1 for client #621. Review on 05/12/20 of the facility's care of patient policy dated 10/01/16 and revised 04/03/20 revealed the following about level of supervision: -A staff member is assigned to monitor the patient and remain within arm's length at all times -Assigned staff will document the patient's behavior, location, activity, special precautions (as indicated) and ensure the patient is no longer in danger or distress During interview on 05/13/20, MHT #11 reported the following occurred on the night of 05/03/20: -She had not previously worked on the 600 hall -She was reassigned due to staffing shortage. Only she, MHT #12 and Nurse #3 worked on the hall with 12 clients. -Client #621's 1:1 responsibilities were assigned for all staff. That meant, each staff rotated their 1:1 time schedule. MHT #12 provided 1:1 from 7:30-9:00 PM. MHT #11's 1:1 services began at 9:00 PM. She nor MHT #12 left client #621 unsupervised. During interview on 05/13/20, MHT #12 reported the following occurred on the night of 05/03/20: -Verified she and MHT #11 monitored all 12 clients -Schedule was 7:30-7:45 PM: bath time for those who needed it...7:40- 8:15 PM: medication administration..8:15-9:00 PM: television watching in the day room...9:00 PM: bedtime for everyone -All clients sat in the hallway outside their doors during bathing and medication administration. Only a few clients needed to bathe. She assisted the nurse with medication administration. She stood by the clients as medication was administered and assured	V 314		

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V 314	Continued From page 9 medications were taken. -During television time, client #621 decided he didn't want to watch television and preferred to go in his room. She stayed in client #621's bedroom with him. Client #704 was initially in the dayroom, then decided to go in the bedroom. As she sat in the bedroom in a desk area, clients #704 and #621 played basketball using the laundry basket. "They got a little aggressive with wrestling." Client #621 reported he was tired/ready for bed, client #704 left the bedroom. Less than five minutes later, client #621 wanted to get back up and go into the dayroom. With five minutes left until 9:00 PM, client #621 returned back to the bedroom. She remained with client #621 until she was relieved by MHT #11. During interview on 05/14/20, the Chief Officer of Nursing (CON) reported the following: -The nurse on the hall completed the staff's daily assignment sheet. A specific person should have been assigned the 1:1. If staff rotated, that should have been noted. -Regardless of the staffing numbers, the nurse should have assured supervision of the 1:1 client. D. Elopement using staff badge Review on 05/19/20 of client #709's record revealed: -Admitted: 03/12/20 -Diagnoses: "Major Depressive Disorder, Unspecified Alcohol related Disorder, Unspecified Hallucinogen related Disorder, Cannabis Disorder and Oppositional Defiant Disorder" -Treatment plan updated 05/11/20 listed history of poly substance use, elopements and aggressive behaviors -Age: 15	V 314		

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	20140058		C 05/26/2020

NAME OF PROVIDER OR SUPPLIER
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V 314	Continued From page 10 Review on 05/19/20 of client #725's record revealed: -Admitted: 05/04/20 -Diagnoses: "Major Depressive Disorder, Unspecified Trauma & Stressor Related Disorder, Purging Disorder, Reactive Attachment Disorder and Borderline Traits" -Treatment plan dated 05/06/20 listed behaviors inclusive of suicide attempts, self harm and eating disorder -Physician's orders noted the following level of supervisions : 05/12/20 "Close observation at all times" ..05/13/20 "Close observation while awake" -Age: 17 Review on 05/26/20 of the staff assignment sheet dated 05/14/20 between 7:00 AM- 7:00 PM revealed the following: -Special observations at all times (4 clients) -Initials correlating to MHT #15 and #16 were noted as responsible staff for monitoring During interview on 05/19/20, MHT #16 reported: -She worked on the 700 hallway on 05/13/20. -She reported to management, she suspected 4-5 clients had planned to elope. She heard conversations between the clients and some of the clients had a history of elopement. All clients involved in that conversation were placed on close observation. Client #725 was already on close observation but she did not recall if she was aware of his level of supervision. -Close observation meant eye sight of staff and documentation of activities at least every 15 minutes. During interview on 05/19/20, client #709 reported the following about 05/14/20:	V 314		

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V 314	Continued From page 11 -Initially, he and 5 peers had discussed eloping from the facility. -He had planned to distract staff, take the key card and elope with his peers immediately. His attempts to distract staff by allowing deodorant to fall out his pocket were unsuccessful. -While being transported from the cafeteria back to the hallway, he walked up to MHT #16, asked if he could ask a question and grabbed her key card located around her neck. He and client #725, ran through the hallways and eloped out the front door of the facility. -He estimated they were gone for an hour. During interview on 05/19/20, MHT #16 reported the following about 05/14/20: -She worked 7:00 AM-7:00 PM Shift - On 05/14/20, before 12 Noon, MHT #13 had been reassigned to another hall and MHT #14 worked until 5:00 PM. -She kept her key card around her neck. She did not recall being told where to keep her key card. -Around 5:30 PM, she and MHT #15 transported 7-9 clients to the cafeteria for meals. Nurse #4 remained on the hall with 1-2 clients who remained on the hall as opposed to eating in the cafeteria. -When she returned back to the hallway, her hands were filled with meal trays for the clients that did not eat in the cafeteria. Client #709, asked if he could ask a question but instead snatched her key card from around her neck. The lanyard had a "breakaway" which made it easy to grab. During interview on 05/21/20, the DOC/RM reported the following about 05/14/20: -Although not documented on the staff assignment sheet for 05/14/20, not all staff that	V 314		

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V 314	Continued From page 12 provided coverage were noted on the assignment sheet completed by the Nurse. -The census was 10 and consistently 3 MHTs were on duty throughout the shift. The changing of staff and coverage was not clear on the assignment sheet completed by the nurse. -At the time of the elopement, it was her understanding a third MHT staff was on the hallway with the nurse. She acknowledged the staffing pattern of 2 staff to 7-9 clients for the meal time and transporting. -She acknowledged this was the second elopement in which key cards were obtained by clients. The agency was in the process of exploring different vendors to address the concerns. During continued interview on 05/21/20, the DOC/RM reported: -Internal investigations were conducted after each elopement and sexual allegation identified. -Retraining of staff and accessing systems to assure compliance were ongoing efforts by the agency -With the addition of the recruiter for hiring and the internal quality assurance/improvement systems, she anticipated changes with staff supervision of clients and staffing numbers to maintain coverage. Review on 05/21/20 of the facility's Plan of Protection dated 05/21/20 submitted by the DOC/RM revealed the following: "-What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? Compliance Director and Milieu Managers to immediately audit staffing for the current shift, and allocate Crisis Prevention Intervention trained leadership team members if necessary, to fill any gaps in	V 314		

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V 314	Continued From page 13 staffing. Effective immediately and until further notice, Milieu Managers will do a headcount of assigned MHT staff at the time clock as they arrive and immediately report tardy arrivals or no-shows to the House Supervisor and Administrator on Call (AOC). The AOC will be responsible for immediately reallocating appropriately trained team members including therapist, admission counselors and appropriately credentialed leadership team members to patient care vacancies until they are relieved by a PRN (as needed) team member. Nursing Management will provide shift by shift training until all the nurses are retrained on the proper way to complete the Assignment Sheet correctly, to include ensuring all special precautions will be monitored appropriately and the 2:6 ratio is documented. Nursing Management will provide shift by shift training to all nursing staff on the above rule violation that is cited to ensure the 2:6 ratio is always being adhered to. This training is to include but not limited to maintaining ratio during transitioning patients and maintaining ratio with any special levels of precautions. PRTF admissions will be placed on hold not to exceed 18 females and 30 males until we have resolved our current staffing issues. Nursing will continue to conduct audits of all 1:1's daily to ensure appropriate monitoring. This audit will include review of all physician's orders, the assignment sheets and the level of observation flowsheets to ensure appropriate monitoring. -Describe your plans to make sure the above happens. The AOC will collaborate with the House Supervisor (HS) and conducts daily audits to check ratios and address immediately by reallocating staff as necessary with the CEO's (Chief Executive Officer) authority. HS will personally round at shift change for the next 72	V 314		

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V 314	Continued From page 14 hours to ensure that shift change headcount is in place as described and then hand off responsibility to the AOC to verify ratios through in-person. Nursing Management or designee will round shift by shift to review and collect the assignment sheets to ensure they are completely corrected, and all patients are being properly being monitored as per the census and special precautions level. Random monitoring will be conducted shift by shift by a member of leadership or nursing management to ensure ongoing compliance. Weekly, the leadership team will reevaluate the PRTF admissions to determine next steps as warranted by the staffing needs at that time. The results of the audit will be reviewed in the monthly Quality/PI, MEC and Quarterly Governing Board committees." This facility serves adolescents with psychiatric and behavioral diagnoses. Clients ranged in ages 12-17 with diagnoses inclusive of Post Traumatic Stress Disorder, Disruptive Mood Dysregulation Disorder, Conduct Disorder, Major Depressive Disorder, Attention Hyperactivity Defiant Disorder, Bipolar, Sexual Behaviors, Oppositional Defiant Disorder, Unspecified Alcohol related Disorder, Unspecified Hallucinogen related Disorder and Cannabis Disorder. Clients at the facility had histories of behaviors such as aggression, elopement, car theft, robbery, suicidal ideas and victim/perpetrator of sexual abuse. These behaviors and psychiatric diagnoses warranted a secure residential placement to meet their treatment needs. Between March-May 2020, the lack of required staff ratios as well as staff supervision were root causes of at least four occurrences. These occurrences included the following staff to client ratios and incidents: 1:10 ratio in which one client	V 314		

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V 314	Continued From page 15 eloped from the roof, 3:12 ratio in which two clients used a key card found during an earlier work shift to runaway from the facility, 2:12 ratio in which a client assigned 1:1 was alleged to have raped a peer and 2:9 ratio in which two clients were able to obtain a staff's key card while being transported back to the unit after dinner. These absent without leave/elopements which lasted between 1-5 hours and the rape allegation put the clients at substantial risk of serious harm. This deficiency constitutes a Type A2 rule violation for substantial risk of serious harm and must be corrected within 23 days. No administrative penalty has been assessed. If the violation is not corrected within 23 days, an administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day. This deficiency constitutes a re-cited deficiency.	V 314	V315 starts here A. The procedure for preventing the deficiency and implementing the acceptable plan of correction for the specific deficiency identified. After exiting with DHSR an immediate Plan of Protection (POP)bb was put in place on 5/21/2020. The CEO met with leadership members to discuss the findings of the Survey and the A2 to create the POP. C) <u>The monitoring procedure to ensure that the plan of correction is effective.</u> (1) Daily reporting of staffing is discussed in morning meetings with hospital leadership any issues are addressed immediately, (2) 100% of the PRTF unit staffing is being monitored by the Milieu Managers & House Supervisors as they conduct headcount of assigned staff. This process is being performed daily (3) Nursing Management or designee round shift by shift and collect the assignment sheets to ensure they are completed correctly, and all patients are properly being monitored as per the census and special precautions level. (4) Random documented monitoring will be conducted shift by shift by a member of Leadership or nursing management to ensure ongoing compliance. (5) Weekly leadership team reevaluate the PRTF admissions hold to determine next steps as warranted by the staffing needs at that time. (6) Fulltime recruiter hired for nursing staff needs on 5/12/2020. Daily report from HR Manager regarding the current staffing issues to include offers made for Nurses and MHTs and schedule New Employees Orientation A summary of the findings is being forwarded to the Morning Meeting of Hospital Leadership Monday-Friday. The monthly Quality PI Council, 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.	B) 5/21/2020 POP put in place 5/12/2020 FT Recruiter hired
V 315	27G .1902 Psych. Res. Tx. Facility - Staff 10A NCAC 27G .1902 STAFF (a) Each facility shall be under the directiona physician board-eligible or certified in child psychiatry or a general psychiatrist with experience in the treatment of children and adolescents with mentalillness. (b) At all times, at least two direct care staff members shall be present with every six children or adolescents in each residential unit. (c) If the PRTF is hospital based, staff shall be specifically assigned to this facility, with responsibilities separate from those performedon an acute medical unit or other residential units. (d) A psychiatrist shall provide weekly consultation to review medications with eachchild or adolescent admitted to thefacility.	V 315		

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V 315	Continued From page 16 (e) The PRTF shall provide 24 hour on-site coverage by a registered nurse. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to meet minimum staffing requirements. The findings are: Review between 04/22/20 and 05/20/20 of 11 audited clients' (#702, #594, #621, #704, #709, #255, #671, #680, #626, #673 and #725) record revealed the following examples of their histories, behaviors and age ranges: - Histories: verbal/physical/sexual abuse, sexual offenders, neglect, substance abuse, trauma, poor social/communication skills and legal/educational issues - Identified behaviors: physical/verbal aggression, sexualized behaviors both victim and perpetrator, suicidal/homicidal ideations and attempts, severe agitation, anger issues, oppositional, attention-deficit/hyperactivity disorder and impulsiveness -Ages: 12-17 years old During interview on 05/01/20, the Director of Compliance and Risk Management (DOC/RM) reported: -The MHT (Mental Health Technician) staff/client ratio should be 2:6 -When 7-10 clients are present 3 MHTs should be on duty -If the residential hall was short MHTs, the nurse should be utilized for coverage	V 315	.D) Title of person responsible for implementing the appropriate plan of correction. Interim DON, HR Manager, DQCR,	

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V 315	Continued From page 17 During interview on 05/14/20, the Chief Officer of Nursing (CON) reported the following: -Facility operated based on two rotations, identified as blue and pink. Each rotation had a day and a night shift. -Agency has in place a systematic system for non medical staff to report shift related concerns via the following organizational hierarchy- MHT, Regional Counselor (RC), Milieu Manager, House Supervisor, Administrator on Call (AOC) and CON. For medical personnel the organizational hierarchy was Nurse, Nurse Supervisor/House Supervisor and the CON. The Milieu Manager or the RC assists with coordinating daily staff for each residential hall and MHT education. -At the end of each shift, the House Supervisor or the Milieu Manager in charge completes a "Matrix." The "Matrix" provided daily staffing numbers, 1:1 assignments, client census as well as document any unusual occurrences per residential hallway. The "Matrix" is submitted daily to the CON and the CEO (Chief Executive Officer) either in writing or via email. The following are examples of incidents that occurred between March-May 2020 in which the facility failed to meet staff to client ratio of 2:6. A. Review on 05/11/20 of the facility's internal investigation report revealed the following occurred on 03/28/20: -3 MHTs were assigned to the unit as well as one nurse (#1). -Between 11:51-11:59 AM, MHT #1 was the only staff consistently in the courtyard with 10 clients. -Client #702 eloped by jumping on the roof During interview on 05/14/20, the CON reported the following for the 03/28/20 incident on the 700	V 315		

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V 315	Continued From page 18 residential hall: -She was not sure how many staff were actually on duty -It was her understanding one staff was outside with the clients - "It's not a standard" staff to client ratio for the facility B. Review on 05/11/20 of the facility's internal investigation report revealed the following occurred on 04/13/20 on the 700 residential hall: -While being transported from the education hallway to their residential hallway earlier in the day, clients #702 and #594 found a key card on the floor. Clients were able to hide the key card from staff. -Identified two MHTs (#4, #5) and one nurse (#2) involved with clients around 9:00 PM. -At 9:30 PM, clients #702 and #594 used the key card found earlier in the day to elope. During interview on 05/14/20, MHT #4 reported for the occurrence on 04/13/20: -He could not recall the client census but it would've been either 10 or 12. Based on census of 10 clients, it should've been 4 MHTs on duty -Besides himself, MHT #5 and MHT #6 worked "for sure. Maybe another staff worked?" He did not recall any other MHTs who worked that night. If another staff worked, he could not recall what the other staff did when the clients eloped . He recalled the nurse was on duty. During interview on 05/14/20, the CON reported the following for the occurrence on 04/13/20: -She nor the CEO could locate the Matrix for this date. -During this interview, a House Supervisor informed her 12 clients were on the residential hall and 5 MHTs (#4, #7, #8 worked entire shift	V 315		

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V 315	Continued From page 19 .....#9 worked until 11:45 PM then #10 came on duty) the night of 04/13/20. These would have been the same staff that worked 04/12/20 and 04/14/20. C. Review on 05/11/20 of an internal investigation report revealed the following occurred on 05/03/20 on 600 hallway: -Client #621 had physician's orders for 1:1 staffing due to exhibiting sexualized behaviors since 04/18/20 -MHT #11 and MHT #12 were the only staff on duty on the hallway between 7:00 PM.-7:00 AM -An allegation of rape was made against client #621 by his roommate client #704 During interviews on 05/12/20- 05/13/20, MHT #11 and MHT #12 reported the following about 05/03/20: -Verified only two MHTs worked the 600 hall the night of 05/03/20. The RC was in charge of the entire building and provided assistance for breaks. The RC did not remain in coverage the entire shift, just for intermittent times -The shift rotation they worked was called "pink" nights. -The pink night rotation had been short staffed for months specifically on Sunday nights -The staffing pattern should have been a total of 5 because their was a 1:1 and the census was 12. During interview on 05/13/20, the RC reported the following occurred on the night of 05/03/20: -He was on duty. -The building did not have a Milieu Manager so he was in charge of census gathering for the House Supervisor, rotating on the halls, making hourly rounds and giving staff breaks.	V 315		

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V 315	Continued From page 20 -Due to his increased work duties, he was not able to provide coverage on the 600 hall During interview on 05/12/20, the Director of Utilization Review reported the following about 05/03/20: -On 05/03/20, she served as the AOC. -She was made aware on 05/03/20 of of the shortage in staff on the 600 hall at night. -Although the staff informed her, they should have notified the CON. During interview on 05/14/20, the CON reported the following about 05/03/20: -The RC would have made assignments that night to accommodate needs of the residential units. The first priority would have been to assure the 1:1 or special monitoring was covered. That night, the RC was in and out the hall, the nurse provided some coverage. She was not aware of the staffing shortage the night of 05/03/20. D. Review on 05/15/20 of an Incident Response Improvement System report revealed the following occurred 05/14/20 around 5:55 PM: -Clients #725 and #709 "eloped from the facility around 5:55pm, patient had snatched a staff member's access key (key card) while in transition line at 700/800 doc (documentation) station. Patient used the access key to elope. Staff responded immediately, calling a 'code Green'. Patient was returned to the facility at 6:50pm by the [local] Police Department." Review on 05/19/20 of the facility's assignment schedule dated 05/14/20 between 7:00 AM-7:00 PM revealed the following: -Client Census: 10 -MHT's Assigned: 3 -Handwritten note at the top of the form	V 315		

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V 315	Continued From page 21 referenced MHTs #13-#16...MHT #13 was reassigned to another hallway to provide 1:1 Services. During interview on 05/19/20, MHT #15 and MHT #16 reported the following about 05/14/20: -At the beginning of the shift, 3-4 MHTs and a nurse were on duty. -Prior to lunch, MHT #13 was reassigned to provide 1:1 services with a client on a different hall. -MHT #14 shift ended at 5:00 PM as he had picked up an extra shift. -Dinner was between 5:30-6:00 PM. The nurse remained back in the unit with 1-2 clients who did not eat in the cafeteria. -Both MHTs monitored 7-9 clients for mealtime including transporting to and from the cafeteria. During interviews between 05/07/20 and 05/20/20, the DOC/RM reported the following: -After each of the incidents noted above, a training was held to discuss staffing ratio of 2:6. Training for staffing patterns was completed 05/07/20. -Disciplinary action for some staff, accountability of staff for attendance as well as the use of clinical staff were discussed as course of actions to address the staffing matter. During interview on 05/13/20, the RC reported the following: -Sundays were normally the worst days for the "pink shift" rotation. "Pink shift" rotation's weekend to work was also payday. MHTs normally picked up extra shifts, except on pay weekend. -During times of staff shortage steps such as calls made to a list of as needed (PRN) staff, on	V 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	20140058		C 05/26/2020

NAME OF PROVIDER OR SUPPLIER
STRATEGIC BEHAVORIAL CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
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 315	Continued From page 22 duty staff were asked to work an additional few hours for coverage as well as on duty staff reassignment within the facility based on treatment needs. During interview on 05/14/20, the CON reported the following: -Staff shortages were "seasonable" and not constant for one shift. -She was not sure how long the shortages had been going on. "It's an ongoing issue." -Reasons for shortages included hiring, firing trends and call ins. -The facility utilized professional staff for coverage as well as certified nurse assistants via a temporary agency for coverage. Recently, the facility hired a recruiter to start 05/18/20. The recruiter would hire staff to accommodate the needs of each shift. This deficiency is cross referenced into 10 A NCAC 27G.1901 Psychiatric Residential Treatment Facility for Children and Adolescents-Scope (V314) for a Type A2 rule violation and must be corrected within 23 days.	V 315		

STRATEGIC
BEHAVIORAL CENTER

June 24, 2020

NCDHHS/DHSR
India Vaughn-Rhodes, Facility Compliance Consultant I
1800 Umstead Drive
Williams Building
Raleigh, NC 27603

RE: A2 POC for May 26, 2020 complaint survey. Intake #NC164351, #NC164336, #NC164359, #NC164141, #NC163914, #NC165677, #NC162370 and #NC162008.

Dear Mrs. Vaughn-Rhodes:

Please see the attached A2 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 and their families that have entrusted us with their care.

Respectfully,

Joe Dunston, CEO

Enc: Plan of Corrections

qsj

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