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 _____	10/07/2020

DHSR - Mental Health

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

OCT 30 2020

Lic. & Cert. Section

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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on October 7, 2020. Two complaints were substantiated (intake #NC00169579 and NC00167019) and four complaints were unsubstantiated (intake #NC00169558, NC169676, NC00168439 and NC00167947). 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 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	V 105	Begin V105 **a) The procedure for preventing the deficiency and implementing the acceptable plan of correction for the specific deficiency identified:** 1)The DQCR and Risk Management Depeartment has been re-educated on requirements related to reporting serious occurrences to both the State Medicaid agency and DRNC. It has been emphasized that this report must be made no later than close of business the next business day after each serious occurrence, as defined in 483.352. 2) Hospital leadership have been educated on the requirement that serious occurrences, as defined in 483.352, shall be reported to the DQCR immediately, in her absence, the CEO, to ensure that the reporting requirement of a report to Medicaid and DRNC no later than close of business the next business day is upheld. In order to remain on the schedule, staff not in attendance for the training are required to receive training on this requirement prior to any scheduled work by the completion date.	

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V 105	Continued From page 1 can provide services to address the individual's needs; and (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	**c) The title of the person responsible for implementing the acceptable plan of correction:** The Director of Quality, Compliance, and Risk Management **d) 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 regulatory requirements:** 1)Compliance with the requirement to report to the State Medicaid Agency and DRNC no later than close of business the next business day will be monitored as follows: The DQCR will present information on any serious occurrences, as defined in 483.352, to the CEO on a M-F basis. The DQCR shall present evidence to the CEO that the report to the State Medicaid Agency and DRNC has been made no later than close of business the next business day by comparing and showing the date/time the hospital was made aware of the incident to the date/time the report was made. The DQCR will document that this review has occurred. Compliance with this requirement will be addressed through the progressive disciplinary action process. 2) Evidence of the DQCR's compliance with reporting requirements will be reported daily 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.	

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V 105	Continued From page 2 This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to implement written standards that assured operational and programmatic performance meeting applicable standards of practice to report serious occurrences to the State designated Protection and Advocacy system. The findings are: Review on 9/30/2020 of the LME-MCO (Local Management Entity-Managed Care Organization) communication Bulletin J287, "Clarifying the Reporting Standards for Psychiatric Residential Treatment Facilities (PRTF)" dated 5/11/18 revealed: -" ...Serious Occurrences are any event that result in Restraint or Seclusion, Resident's Death, Any Serious Injury to a Resident, and a Resident's Suicide Attempt. NC § 483.374 specifies that facilities must report each Serious Occurrence to both the State Medicaid agency (Division of Medical Assistance - DMA) and, unless prohibited by State law, the State-designated Protection and Advocacy system (Disability Rights North Carolina - DRNC)." -"DRNC reports are to be faxed to (919) 856-2244." Review on 10/06/20 of facility restrictive intervention records from 7/1/20 thru 09/30/20 revealed no serious occurrences involving seclusion or restraint had been reported to DRNC as required for the following clients: - Client #2 - Restraint on 08/04/20 and 08/26/20. - Client #6 - Restraint on 07/29/20 x 2 and	V 105		

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V 105	Continued From page 3 08/25/20. Interview on 09/30/20 Director of Quality Compliance/Risk Management stated: - The facility had not typically notified DRNC when clients were placed in seclusion or restraint. - She was not aware DRNC had to be notified when a serious occurrence including restraint or seclusion was used on PRTF clients. [This deficiency constitutes a re-cited deficiency and must be corrected with 30 days.]	V 105		
V 315	27G .1902 Psych. Res. Tx. Facility- Staff 10A NCAC 27G .1902 STAFF (a) Each facility shall be under the direction a physician board-eligible or certified in child psychiatry or a general psychiatrist with experience in the treatment of children and adolescents with mental illness. (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 performed on an acute medical unit or other residential units. (d) A psychiatrist shall provide weekly consultation to review medications with each child or adolescent admitted to the facility. (e) The PRTF shall provide 24 hour on-site coverage by a registered nurse.	V 315		

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V 315	Continued From page 4 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure at least 2 direct care staff were present with every 6 children or adolescents at all times. The findings are: Finding #1 Observation and interview with unidentified staff on 9/30/20 during a tour of the facility from approximately 12:10PM to 12:20PM: - Hallway 200 - 14 clients with 3 staff; 1 staff was on break - Hallway 400 - 12 client and 2 staff; 1 staff was on break and 1 staff had left for the day. Interview on 9/30/20 client #6 stated: - Lived here 10 months - was in acute unit for 4 months and then 7 months at the PRTF (Psychiatric Residential Treatment Facility) - Currently on the 100 hallway - 13 clients on that hall - "Sometimes we be short-staffed." Sometimes on the weekdays it's usually 3 and sometimes it's 2. 2nd shift it's usually 4. "It's only really on 1st shift that we're really short-staffed." - In regards to an incident that happened in July 2020 "That's one of the days that we didn't have enough staff. We had like 3 staff on that hall. We're supposed to have like 5 staff on that hall. There was about like 3 nurses on the hallway when the restraint was going on." Finding #2 Review on 09/17/20 of [Facility] Investigation Reporting Form dated 12/10/19 revealed: - Summary of Event: "On the evening of December 6, 2019 around 2130, several PRTF [Psychiatric Residential Treatment Facility]	V 315	Begin V315 **a) The procedure for preventing the deficiency and implementing the acceptable plan of correction for the specific deficiency identified:** 1) A daily review of staffing coverage for all shifts is now being reported to the Hospital's Morning Meeting of leadership staff. Shifts out of compliance with staffing are addressed through PRN coverage or leadership assisting with any deficits in same. 2) Whenever there is a patient event requiring a Root Cause Analysis, the adequacy of staffing is assessed to determine if staffing might have been a factor in the occurrence or prevention of same. **c) The title of the person responsible for implementing the acceptable plan of correction:** Director of Nursing **d) 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 regulatory requirements:** 1) On a daily basis, the Director of Nursing is now reporting on compliance with staffing requirements for all units. 2) The findings are reported daily in the Hospital's Morning Meeting. The findings, conclusions, recommendations, and actions taken are being 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	

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V 315	Continued From page 5 residents began displaying unsafe behaviors; kicking off hallways, inciting others to act out, and others were placed in physical holds. Due to the multiple restraints and unsafe behaviors occurring, the nurse supervisor, [Nurse Supervisor], contacted law enforcement via 911 to provide additional security measures. [On-call]] was immediately called, and [Facility] leadership and the Medical Staff Director responded to the event." - Root Cause Analysis Findings: "(1) 19 staff were scheduled for 2nd shift. (2) 2 staff called out. (3) 2 staff left at 8pm." Review on 09/25/20 of the facility's Client Census Record for 12/06/20 revealed: - 70 PRTF clients resided at the facility on 12/06/20 Review on 9/25/20 of the facility's Time-In and Time Out Record for week of 12/06/20 revealed: - 13 Mental Health Technicians (MHT) were identified as working during time of incident on 12/19/20. - 1 MHT-II was identified as working during time of incident on 12/19/20. - I Milieu Manager (MM) was identified as working 8am - 5pm but confirmed to have been working during the time of the incident on 12/06/20. Interview on 9/10/20 staff #1 stated: - She was working on the night of 12/06/19. - There were not enough staff to cover the clients on the evening of 12/06/19. - Staff to client ratio may have been 2 staff to 18 clients on the evening of 12/06/19. - There were not enough to staff to handle the incident on 12/06/19 and local law enforcement was contacted to assist.	V 315		

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V 315	Continued From page 6 Interview on 10/01/20 staff #2 stated: - She was working on night of 12/06/19. - She was uncertain of the staff to client ratio on evening of 12/06/19. - The hall lead left her shift early. - There were not enough to staff to handle the incident on 12/06/19 and local law enforcement were contacted to assist. Interview on 09/18/20 Director of Quality Compliance/Risk Management stated: - In addition to the MHT's working on 12/06/19 there was also 1 MM and 2 nurses working. - With 2 staff callouts, and two staff leaving early, it was possible that the facility was not in compliance with staff to client ratio on 12/06/19.	V 315		