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 _____	11/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVIORAL CENTER-GARNER	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 Follow Up and Complaint Survey was completed 11/25/20. The complaints were unsubstantiated (Intake #NC00172251, #NC00169584, #NC00169289, #NC00171503, #NC00171347, #NC00171346, #NC00170657, #NC00170658, #NC00170616, #NC00169584) and substantiated (Intake #NC00168370, #NC00171587, #NC00170650, #NC00170422, #NC00172242). 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) 12/14/2020*
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care	V 132	*V132 starts here* ***a) The procedure for preventing the deficiency and implementing the acceptable plan of correction for the specific deficiency identified.*** 12/7/2020 facility wide training commenced to include patient abuse, incident reporting therapeutic boundaries, and zero tolerance for staff not reporting serious incidents Staff was reeducated on the steps for completing and reporting incidents to include calling the Compliance Director. Signage will be posted on every unit near the patient's grievance boxes to remind the patients to please report all concerns, complaints and or grievances to their nursing staff for immediate attention. The Patient's complaint/grievances boxes will be checked by Nursing Management over the weekend and reported to the Compliance Director to ensure timely 24 hrs. follow up.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: James Wilfer — TITLE: Interim CEO — (X6) DATE: 12-15-20

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V 132	Continued From page 1 facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to protect residents from harm while the investigation was in progress. The findings are: During an interview on 11/20/20, client #758 reported: -She filed a grievance form on 11/13/20 at 5:55P. -Resolution to grievance was to keep accused staff Mental Health Tech (MHT #12) off 400 hall. -Staff jumped up in "my face like she was going to fight me." During an interview on 11/24/20, Director of	V 132	***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.*** The Human Resource Director will ensure that all staff has completed the training by the required timeframes. Both the Interim CNO and the Human Resource Director will be kept abreast of any serious occurrences that was not reported by staff for any further actions. The Compliance Department will crosswalk the complaints/grievance with incident reports to ensure compliance with reporting requirements. Also, if it is determined that staff was aware of any patient's complaint/grievance and failed to report disciplinary actions may be imposed. ***d)The title of the person responsible for implementing the acceptable plan of correction.*** The Interim CNO, Human Resource Director and the Compliance Director. *V132 ends here*	

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V 132	Continued From page 2 Quality, Compliance & Risk Management reported: -When grievances happen they are put in a grievance box, checked by the compliance department. -Grievance box is checked daily, except when grievances are placed in the box on Fridays after 5P they are not checked until Monday. -When nursing staff are aware of the grievances they should contact Director of Quality, Compliance & Risk Management. -The accused staff did work the weekend, put on administrative leave on Monday 11/16/20 when grievance was retrieved out of the grievance box. During an interview on 11/18/20, MHT staff #4 reported: -Observed MHT staff #12 accused pointing and yelling at client #758. -Heard MHT did engage in cursing and called her a B***h. -Registered Nurse physically put herself in between the client and staff. During an interview on 11/20/20, MHT former staff (FS) #12 -Worked on the 400 girl's hall Friday 11/13/20, Sunday 11/15/20 and on the 500 boy's hall on Saturday 11/14/20 -Did not use profanity at any of the girls. -Client #758 was aggressive and used profanity. -Was called Monday 11/16/20 and placed on administrative leave. Record review on 11/20/20 revealed: -Grievance was completed Friday, 11/13/20 at 5:55P by client #758 -Patient Advocate reviewed grievance form	V 132		

Division of Health Service Regulation

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V 132	Continued From page 3 on 11/16/20 and investigation started on Monday 11/16/20 -FS #12 was placed on administrative leave on 11/16/20	V 132	*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* *V314 starts here* ***a) The procedure for preventing the deficiency and implementing the acceptable plan of correction for the specific deficiency identified.*** a) Upon hire the Human Resource Department (HRD) conducts background checks on all staff. Additionally, all staff must go through a 2-week New Employee Orientation (NEO) to include Patient Abuse, Therapeutic Boundaries, and Incident reporting. Strategic has a process in place for reporting and investigating all allegations. These processes were used to investigate items A-D with the appropriate disciplinary actions to follow. All investigations will be reviewed in Patient Safety and if any trends are identified an immediate action plan will be put in place. Additionally, facility wide reeducation/training started on 12/7/2020 to include but not limited to Patient Abuse, Therapeutic Boundaries, Incident Reporting. Staff was also informed of the results of the survey. ***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.*** To ensure compliance, 100% of all investigations will be reviewed in the Patient Safety Committee meeting for review and to identify any trends and action items. The CEO will be made aware of all investigations. Also, the HRD will ensure all staff has completed all required training	b) 12/14/2020
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 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	V 314		

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V 314	Continued From page 4 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 meet supervision requirements, provide therapeutic interventions and coordinate services. This affected 13 of 13 audited clients (#625, #675, #692, #709, #717, #726, #756, #758, #767, #768, #769, #729 and #741) 1 of 3 former audited clients (#594). The findings are: I. Cross reference: 10A NCAC 27G. 1902 Staff (V315). Based on record review and interview, the facility failed to meet minimum staffing requirements. II. The following are examples of non-therapeutic interventions Review between 09/04/20 and 10/07/20 of client #741's record revealed the following: -Admitted: 08/01/20 -Diagnoses: Disruptive Mood Dysregulation Disorder, Depression and Attention Deficit Hyperactivity Disorder (ADHD) -History: elopement, mood outburst, suicidal/gestured homicide, sexual relations with	V 314	with any staff not in compliance by the deadline follow up to follow. 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. ***d)The title of the person responsible for implementing the acceptable plan of correction*** The HRD and the Director of Compliance/RM **III. Examples of lack of supervision** A Plan of Protection was implemented on 10/12/2020 to include the following: **What immediate action will the facility take to ensure the safety of the consumers in your care?** The leadership team met to review the current census and the full-time staffing for each shift and each rotation to ensure that we are adequately staffed at our current census level. After re-evaluation of our staffing schedule, it was determined that re-allocation of staffing (e.g. days, nights) was needed to ensure compliance with our 2:6 ratio for all shifts/rotations. Currently, we have 10 MHTs completing New Hire Orientation (NEO) that are completing training this week and will be available to start on the hospital's full-time MHT schedule on 10/19/20. Starting today, all PRTF admissions will be held until we demonstrate for 14 consecutive days that we meet and maintain the 2:6 MHT ratio. Additionally, from 10/21-10/25, mandatory facility wide Level of Observation training to include but not limited to Level of Observation documentation, 1:1 and Line of Sight (LOS) monitoring was provided by VP of Clinical Services & Regulatory Affairs.	b) 12/14/2020 **10/25/2020** Levels of Observation training completed

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V 314	Continued From page 5 peers and self injurious behavior -Age: 14 Review between 09/04/20 and 10/07/20 of client #675's record revealed the following: -Admitted:08/05/20 -Diagnoses: Oppositional Defiant Disorder (ODD), Disruptive Mood Dysregulation Disorder, Depressive Disorder and ADHD -History: cutting, elopement and suicidal ideation -Age: 14 Review between 09/04/20 and 10/07/20 of client #758's record revealed the following: -Admitted: 08/03/20 -Diagnoses: Major Depressive Disorder,ODD and Cannibis use -Age 17 A. Review on 11/13/20 of the facility's investigation of Former MHT staff (FS) #4 between the dates of 11/03/20-11/09/20 revealed: -"Staff was unprofessional and non-therapeutic" per the video review. FS #4 was seen raising a hand as if to strike client #741 and "digging elbow" into the client. -Violation of facility's Policy Humane Treatment "No profane, demeaning, indecent, ethnic or other discriminatory connotation shall be directed toward any client" -FS #4 repeatedly stated "f**k you b***h" and "I will f**k your s**t up" toward client #741 -"The Interim DON (Director of Nursing) and HR (Human Resources) have been made aware of this investigation; HR stated FS #4 was notified of his termination on 11/10/20" During interview on 11/12/20 FS #4 reported: -Came in early to assist on 500 hall	V 314	**Describe your plans to make sure above happens.** The Interim DON will be working in collaboration with the Human Resource Director to address the reallocation of the current MHT staff. The Program Coordinator will follow up with the MHT employees in the NEO class to ensure they are assigned appropriately to ensure compliance with the 2:6 MHT ratio. Strategic Behavioral Center-Graner will be in compliance with the actions on this POP by 10/31/2020.	

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V 314	Continued From page 6 -Had assisted in a 2 person restraint -He had "lost it" and disengaged from the restraint and left the room B. Review on 11/20/20 of the facility's investigation of FS #5 between the dates of 11/10/20-11/12/20 conclusion revealed: -FS #5 grabbed client #675 by the shirt, shoved him across the hall into a closed door and caused him to fall to the floor. -FS #5 "was unprofessional and non-therapeutic" -Violation of facility's Policy Humane Treatment "No profane, demeaning, indecent, ethnic or other discriminatory connotation shall be directed toward any client" -"The Interim DON and HR have been made aware of this investigation; HR [FS #5] was notified of his termination on 11/12/20." During interview on 11/19/20, Facility Maintenance staff reported: -Had worked on a door on the hall -Witnessed FS #5 push client to the floor -Didn't hear cursing or threats toward client #675 C. Review on 11/23/20 of the facility investigation of Lead MHT staff #13 between the dates of 10/30/20-11/05/20 revealed: -Lead MHT staff #13 cursed and stated "I'm going to kill this b***h" and "I can't go outside or I'm going to kill her" in refence to client #758 -Lead MHT staff #13 "was unprofessional and non-therapeutic" -Violation of facility's Policy Humane Treatment "No profane, demeaning, indecent, ethnic or other discriminatory connotation shall be directed toward any client" -"The interim DON and HR has been made	V 314		

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V 314	Continued From page 7 aware of this investigation and will follow up with Lead MHT [staff #13] as appropriate per policy" During interview on 11/12/20, Lead MHT staff #13 reported: -Does recall that he cursed at client # 758 -He was terminated on 11/12/20 D. Review on 11/23/20 of client #758 grievance filed against MHT staff #12 investigation packet revealed: -Investigation began on 11/16/20 involved MHT staff #12 and client #758 -Complaint Grievance from was completed on 11/13/20 by client #758 Review on 11/19/20 of the facility's investigation of witness statement written by Licensed Practical Nurse (LPN) #1 revealed: -Witnessed incident on 11/13/20 that involved MHT staff #12 and client #758 -MHT staff #12 being aggressive toward client #758 -MHT staff #12 was talking loud to client #758 -MHT staff #12 snatched the phone from client #758 During interview on 11/12/20, MHT staff #4 reported: -MHT staff #12 engaged in a "power struggle with patient" -Heard "yelling and screaming" when entered the 400 hall recognized it was MHT staff #12 yelling at client #758 -MHT staff #12 did engage in cursing and called client #758 a "b***h" Interview on 11/24/20, Director of Quality, Compliance & Risk Management (DOQC/RM) reported she:	V 314		

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V 314	Continued From page 8 -Noticed an increase with verbal abuse or non-therapeutic rapport, physical abuse allegations. -Will do a re-education or training, or a booster training in addition to the annual trainings. -It may appear to be a trend but difficult to show with different staff. -Hiring requirements have been changed. III. Examples of lack of supervision Review on 09/21/20 of the facility's care of patient policy effective 10/01/16 revealed the following about Levels of Observation...Line Of Sight (LOS): "-The patient must be in sight of a staff member at all times and 15 minute checks documented. -When patients shower, change clothes or use the bathroom the same sex staff member will remain outside the patient's room or bathroom door with the door slightly opened and visually check the patient. Staff will attempt to maintain the patient's privacy as much as possible; however, the safety of the patient must be the main consideration. -Assigned staff will document the patient's behavior, location, activity, special precautions (as indicated) and ensure the patient is in no danger or distress. -Staff assigned to LOS must hand off responsibility for maintaining observation of the assigned patients (s) for any break or change of shift. -Patients placed on LOS must have a physician's order to continue such status." A. Review between 09/04/20 and 10/07/20 of client #726's record revealed the following: -Admitted: 06/30/20	V 314		

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V 314	Continued From page 9 - Diagnoses: Major depressive disorder, recurrent and moderate, Generalized anxiety disorder -History: Suicide attempts, cutting -Age: 17 Review between 09/04/20 and 10/07/20 of client #692's record revealed the following: -Admitted 06/05/20 -Diagnoses: ODD, Anxiety, ADHD -History: Self injurious behavior, property destruction -Age: 14 Review on 10/05/20 and 10/07/20 of the facility's internal investigation conducted 09/01/20-09/04/20 revealed the following: -Client #726 and 692 were not being appropriately monitored -FS #1 was unaware clients were on the unit in a room -FS #2 was not aware that 5 clients were left on the unit. -The unit was out of ratio -Supervisions that day were 3 of the 5 clients were LOS including client #692. During interview on 09/18/20, client #726 reported the following: -Did not engage in any sexual activity with peer -Was asked by peer to engage in sexual activity -Staff was not monitoring peer who was on LOS During interview on 09/16/20, client #692 reported the following: -Did have "inappropriate" contact with peers, many times	V 314		

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V 314	Continued From page 10 -Recalled being left on the hall with 1 staff with other peers (did not recall staff name) -Wasn't being monitored at the time -Did not want to discuss the incident anymore During interview on 09/18/20, FS #2 reported the following: -There was not enough staff on the hall that day -Overheard client #692 talking to mother "remembered what happened in the mountains happened again" -Talked with mother on the phone and mother stated he was sexually assaulted on the hall -Client #692 was supposed to be LOS During interview on 09/17/20, FS #1 reported the following: -Staffing was not in ratio that day -1 staff was left 4 clients with LOS -He no longer worked for the facility and didn't want to talk anymore. During interview on 09/18/20, Guardian of client #726 reported the following: -Was told by therapist roommate would be screened before being paired with her son -The roommate should have had line of sight supervision -There had never been any sexual allegations involving her son before -Was in the facility for self harming -She did not assist with after care set up as a part of the team During interview on 09/18/20, Interim DON reported the following: -Roommate assignments should be determined by the floor Nurses and Therapist if Therapist is there	V 314		

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V 314	Continued From page 11 -Client/staff ratio should be 6:2. With 12 clients, the ratio should be 12:4 -There was a lack of observation during the 08/20/20 incident -His role was to provide supervision of the Nurses -Facility had "momentarily staffing shortages" on the hall. During interviews between 09/15/20 and 09/25/20, DOQC/RM revealed the following: -The issue with staffing was ongoing. -There was a full investigtion of the incident -Was in not in ratio during 08/20/20 incident B. Review between 09/04/20 and 10/07/20 of client #729's record revealed the following: -Admitted: 05/15/20 -Diagnoses: Post Traumatic Stress Disorder, ADHD, Depressive Disorder, Victim of Physical Abuse -History: verbal/physical aggression, property destruction and trauma -Age: 13 Review on 10/05/20 of the facility's internal investigation conducted 08/21/20-08/27/20 revealed the following on the 600 hall on 08/20/20: -Client #675 stated at different times he was roommates with clients #741 & #729. He disclosed he had sexual intercourse with peers (clients #741 & #729), while he was roommates with each separately. Both peers denied sexual intercourse occurred. The allegations that involved client #741 occurred months prior on a non PRTF residential hall. -The investigation yielded only client #729 and client #675 were involved in the incident on 08/20/20. Client #729 accused client #675 of	V 314		

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V 314	Continued From page 12 opening the bathroom door, while he was inside and showing them his genitals. Client #675 admitted to showing his genitals to client #729. Client #675 asked to touch client #729 inappropriately. Client #729 stated he did not tell staff about this incident because he did not want to get in trouble. Client #729 stated they never had sexual contact or did anything sexual while they were roommates, or otherwise. -"After patient and staff interviews this investigation is unsubstantiated for any sexual intercourse between [client #675] and his peers. However, it is substantiated for inappropriate sexual behavior, i.e. [Client #675] showing his penis and propositioning his peers for sexual acts. [Client #741] and [Client #729] denied having sexual intercourse with [Client #675]. [Client #675] admitted to exposing his private parts to both peers. None of the patients can provide a date or timeframe for when these incidents took place, for a video review." -No notation of staff or concerns regarding supervision in the investigative report. Review on 09/21/20 of the facility's Matrix report on the 600 hall between 08/19/20-08/22/20 on all shifts revealed the following supervision levels: -Client #729 LOS at all times -Client #675 LOS while awake Review on 10/07/20 of the documentation provided by the DOQC/RM regarding LOS staff assignments on 08/20/20 between 7A-7:30P revealed: -MHT staff #10 was assigned client #741 -FS #1 was assigned client #729 -MHT staff #7 was assigned client #675 LOS while awake During interview on 10/07/20, client #729	V 314		

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V 314	Continued From page 13 reported: -Verified client #675 exposed himself to client #729 in their bedroom on 08/20/20 -The 08/20/20 incident occurred as they resided on the 600 unit. -He reported the incident to a MHT staff immediately -He did not recall having any type of special supervision by MHT staff. During interview on 10/08/20, MHT staff #10 reported: -She last worked on the 600 unit a month and a half ago -She did not recall the specifics on 08/20/20. She did not recall any incident of client exposing himself to peers -She did not recall if she had been assigned LOS for client #741 at any time During interview on 10/08/20, MHT staff #7 reported: -"I work on the 600 hall...I was not on the hall then. I was on the 800 hall. I heard stories about that incident.I heard but I can't recall specifics. I make sure I form a relationship and keep them in line of sight. I watch him, they don't have a dull moment to engage like that because I am watching them and they are watching me." During interview on 09/17/20, FS #1 reported: -He no longer worked for the facility. He had been terminated. His termination was not a result of this occurrence. -It would be difficult for one staff to monitor additional clients that were on the hall. -He did not "want to talk about it no more. God Bless America. Strategic had made their decision."	V 314		

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V 314	Continued From page 14 During interviews between 09/14/20 and 10/10/20, the DOQC/RM reported: -The 08/20/20 investigation into the sexually inappropriate behavior amongst clients focused on the allegation and to whether the incident occurred. The investigation did not focus on supervision level of the clients -Since June 2020, the facility had implemented a scenario type training to address examples and concerns regarding supervision. She felt the agency had "gotten better in some regards but it's an area to grow and coach staff." IV. Examples of lack of coordination of services for Former Client (FC) #594 Review on 10/13/20 of FC #594's record revealed the following: -Admitted: 03/13/20 -Discharged: 07/08/20. Summary dated 07/08/20 -Diagnoses: Post Traumatic Stress Disorder, Disruptive Mood Dysregulation Disorder, Conduct Disorder, Cannabis Disorder and Obsessive Compulsive Disorder -Age: 15 A. Failure to Coordinate possible lateral transfer with treatment team as well as honor request of guardian to not discuss possible plans in front of client Review on 11/18/20 of email communications between FC #594's guardian and members of his treatment team inclusive but not limited to the facility's therapist and the facility's Director of Clinical Services revealed the following: -07/02/20 at 9:24P From the mother directed at the therapist - expressed concerns her request to not discuss "about changes that 'can'take	V 314	*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* **IV. Examples of lack of coordination of services for Former Client (FC) #594** ***a) The procedure for preventing the deficiency and implementing the acceptable plan of correction for the specific deficiency identified.*** A Plan of Protection was implemented on 11/25/2020 to include reeducation to all Clinical staff regarding Clinical Services Policy 1200.2, Case Management/ Discharge Planning Protocol. Additionally, reeducation on coordination of care will be included to ensure all parties i.e. Clinical, CNO, Compliance Director (if warranted to ensure all proper court processes are followed), any required court officials, guardians and MCO to be involved with any difficult discharge planning. Additionally, will review this policy or any other related polices for possible revisions. Also, education will be provided to Clinical staff on patients and or their guardians right to ascertain requested documents from the patient's medical record. Policy 1200.2 Case Management/Discharge Planning Protocol was revised to address Coordination of Care for complex discharges. Additionally, the clinical team and the Medical Records Clerk will be reeducated on the guardians right to request and receive medical records.	b) 12/24/2020

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V 314	Continued From page 15 place???! We ask you at the meeting not to discuss any information with [FC #594] and you still took it upon yourself to do so...Please don't speak with my son about nothing you said you didn't handle his case so why are you starting confusing when we told you it will upset him???" -07/03/20 at 9A- therapist responded he acknowledged FC #594's guardian's concern. He indicated he would like to set up a family meeting and provided dates -07/03/20 at 1:24P, the Director of Clinical Services responded-"I apologize for any confusion but in the meeting just to clarify it was discussed that originally [Therapist] did not take the case because he had a number of tough cases. He is assigned to [FC #594] because he is our veteran therapist. What he was saying was that he did not want [FC #594] at the meeting until it was decided what was to be discussed and potentially upset him and assault staff if not necessary. [FC #594] was escalated yesterday while he was on the phone with you and his probation officer. He thought we did not have a CFT (Child Family Treatment) meeting. To avoid triangulation [therapist] told him outright after running it by me that we were looking at a few options because his behavior is so volatile." During interview on 10/15/20, FC #594's Home Local Managment Entity (LME)'s Child Residential Specialist Supervisor reported the following: -Per her agency notes, a meeting was held 07/01/20 with his treatment team. FC #594's aggression, towards staff and peers. Team members also included his therapist from the facility. It was disclosed a lateral transfer packet was sent to another PRTF for approval. The team was not aware of the lateral transfer until the 07/01/20 meeting. FC #594's guardian was not	V 314	***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.*** The Director of Clinical Services (DCS) will inform the CEO and the Director of Compliance/RM of any complex or discharge planning pertaining to any patients that are court ordered for treatment. The DCS will report out in morning meeting the status of any potential discharges and any barriers. 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 ***d)The title of the person responsible for implementing the acceptable plan of correction*** Director of Clinical Services and Director of Compliance/RM V 314 ends here	

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V 314	Continued From page 16 aware nor were members of the treatment team. During the meeting, it was disclosed he was accepted. FC #594's guardian was not in favor of the lateral PRTF transfer. At the end of the meeting, it was agreed the (LME) would follow up with the proposed lateral transfer PRTF facility. The LME shared and validated concerns regarding the lateral transfer with FC #594's guardian. During the interim, FC #594 would remain at current placement and discussion would continue at the scheduled CFT meeting 07/08/20. During interview on 10/14/20, FC #594's guardian indicated the following: -Verified this PRTF did not obtain consent from her prior to submitting the paperwork for lateral transfer to another PRTF. -At the CFT meeting, it was discussed FC #594 had been accepted. It wasn't until after the meeting, she received correspondence that FC #594 had not been accepted as a lateral transfer. -She asked the team not to discuss the possible transfer plans with FC #594. The following day FC #594 indicated his therapist had told him. B. Failure to coordinate discharge with treatment team Review on 10/15/20 of FC #594's discharge summary signed and dated by the physician at the facility on 07/20/20 revealed the following: -Chief complaint: "Court Ordered." -"Hospital Course:" Admitted to PRTF and "provided with bipsychosocial treatment modality that included individual, group and family therapy as well as medical management and recreational therapy in a controlled environment for psychiatric, residential and academic needs. For	V 314		

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V 314	Continued From page 17 much of the time here, he struggled with physical aggression and had numerous incidents of physical restraint for aggression toward staff and peers. He had a very difficult time taking accountability for his negative behaviors. He would frequently refuse medications at time, could be convinced that it was not in his best interest to take them. His moods when I interacted with him were normally stated to be fine, but he had very low frustration and really struggled with aggressive behavior and interpersonal frustration. He would kick off the unit frequently and he was angry." -Discharge Disposition: He was discharged home with intensive in-home services and medication management. Appointments for these services were set up. Review on 10/26/20 of FC #594's records from his Probation Officer revealed: -Court Docket dated 03/09/20 revealed "The following party...appeared before the court on the 9th day of March 2020 and made a motion for the court to continue the above captioned cases which is scheduled for: 5 deposition on 9th day of March at 9:00 AM...The continuance is requested for the following reason: 8. Other: To identify a PRTF or the JV (juvenile)...The opposing party consents to the continuance. It is hereby Ordered that 1. FOR GOOD CAUSE SHOWN, the above referenced matter will be continued until the 13th day of April 2020 at 9:00 AM." During interview on 10/16/20, the facility's Director of Clinical Services reported the following: - FC #594 had multiple incidents and aggression towards staff. He "didn't have investment in the program. He sent several staff (3-4) to the hospital. The police came and they	V 314		

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said they could not charge him. A decision was made to discharge him due to safety concerns."

-Several treatment meetings that included Department of Social Services (DSS) and Family were held. She was not sure of the dates of the treatment team. The facility asked DSS to assist with securing alternative placement. FC #594 was not mandated to be at the PRTF, he could either go home or to detention after being discharged from the PRTF. FC #594's guardian wanted him home.

-In general, the discharge was reviewed with the team/family. Although the discharge was not a two week notification, it was a week. "I would say it was an emergency," the reason for his discharge. "He had lots of aggression and staff were afraid. In emergencies, it's not typical, if his referral came into us now, I would not accept him." The LME was involved in the discharge meeting. The LME did not agree either way with the discharge. The LME did not provide any options. A letter was submitted to the Medical Director for approval of the emergency discharge. "I didn't think it had to be approved. She agreed with that. But it didn't have to be approved."

During interviews between 10/14/20 and 10/30/20, FC #594's guardian, Probation Officer and LME's Child Residential Specialist Supervisor at the Home LME reported:

-A CFT meeting was scheduled on 07/08/20. Prior to the meeting none of the treatment team members were aware of the facility's plan to discharge the client on 07/08/20.

During interview on 10/14/20, FC #594's guardian reported the following:

-In place of the CFT meeting, a discharge meeting was held. Within hours of the conclusion of the meeting, her son was transported home by

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V 314	Continued From page 19 the PRTF staff the same day. She lived an estimated 2 1/2-3 hours away from the PRTF. During interview on 10/15/20, FC #594's Probation Officer reported: -His concern with the sudden discharge was the team was not provided prior knowledge to prepare or make arrangements for FC #594. -FC #594 was court ordered for PRTF services. -The team did question that FC #594 was not given a 30 day discharge notification nor had a discharge plan been developed/discussed prior to the meeting During interview on 10/15/20, FC #594's Home LME Child Residential Specialist Supervisor reported: -Per her agency's records, a meeting was held 07/01/20. FC #594's aggression towards staff and peers was addressed. Discussion regarding lateral transfer to another PRTF had been initiated by the facility. FC #594's guardian was in opposition so the discussion was to remain at facility and discuss a plan at the CFT scheduled for 07/08/20. A second was held 07/08/20. CFT meeting turned into a same day discharge meeting for FC #594. PRTF referenced incident that occurred on 07/07/20 in which a staff's leg was injured and another staff was seen at the Urgent Care for injuries. The LME was not contacted of any events the night or day before the meeting. The PRTF was discharging him "immediately." -During the 07/08/20 CFT meeting, the Specialist discussed with the PRTF as part of LME contract, prior approval was required for emergency discharges of clients. The process included the submission of paperwork to the Medical Director who provided approval normally	V 314		

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V 314	Continued From page 20 within a 72 hour or less turn around time. During interview on 10/19/20, FC #594's Home LME Utilization Management Child Services Supervisor reported: -In regards to FC #594, no paperwork was submitted for approval for emergency discharge or expulsion from services. -On 07/08/20, the facility did submit a discharge summary for FC #594. -A discharge summary was not the same as the contractual requirement of approval from the Medical Director for emergency discharges or expulsion of services. C. Mom requested information not received Review on 11/18/20 of email communications between FC #594's guardian and members of his treatment team inclusive but not limited to FC #594's Home LME's Children's Care Coordinator (Clinical), Facility's Clinical Assistant Clinical Director and the facility's Director of Clinical Services revealed the following: -07/08/20 at 12:23P- Initiated by FC #594 Home LME's Children's Care Coordinator (Clinical)"...Additionally, is there a specific request form that [FC #594's guardian] need to sign to request his entire medical chart or can she request it in the form of an email? Who specifically does this request need to go to? How long do you anticipate it taking to get this information...?" -07/09/20 at 12:30P- Initiated by FC #594 Home LME's Children's Care Coordinator (Clinical)- Email Specifically addressed the facility's Clinical Director and Assistant Clinical Director..."who does [FC #594's guardian] need to communicate directly with at [PRTF] in order to get a copy of [FC #594]'s entire medical chart? Is	V 314		

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V 314	Continued From page 21 there a specific form that she needs to complete this request? Please provide the process for obtaining this information. Thank you." -07/09/20 at 1:54P- Initiated by the facility's Director of Clinical Services- "I will forward this email to the Director of Medical Records on behalf of [FC #594's guardian]. I believe that she can submit a request for medical records form which we can send her." During interview on 10/14/20, FC #594's guardian reported she: -Had not received any requested medical records or information regarding her son. -Was not provided documentation of her son's aggressive behavior towards staff or peers that lead to his July 2020 discharge During interview on 10/15/20, the Director of Clinical Services reported the following: -A packet was sent for the 07/08/20 discharge of FC #594. -"The mother had not requested any other information to my knowledge." During interview on 10/19/20, the facility's Medical Records Director reported: -For a request of medical records, an authorization to release must be signed. -She was familiar with FC #594. She did not recall a request for him specifically. -Medical records request were maintained in the binder or the computer."I've not sent anything off for him. Not in my book. If I would have gotten a request, I would have that in the binder. No email correspondences about it. None from parents or LME either." Review on 10/12/20 of the facility's Plan of Protection (POP) dated 10/12/20 submitted by	V 314		

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the DOQC/RM revealed the following:

-"What immediate action will the facility take to ensure the safety of the consumers in your care?

The leadership team met to review the current census and the full-time staffing for each shift and each rotation to ensure that we are adequately staffed at our current census level . After re-evaluation of our staffing schedule, it was determined that re-allocation of staffing (e.g. days, nights) was needed to ensure compliance with our 2:6 ratio for all shifts/rotations.

Currently, we have 10 MHTs completing New Hire Orientation (NEO) that are completing training this week and will be available to start on the hospital's full-time MHT schedule on 10/19/20.

Starting today, all PRTF admissions will be held until we demonstrate for 14 consecutive days that we meet and maintain the 2:6 MHT ratio.

-"Describe your plans to make sure the above happens.

1. The Interim DON will be working in collaboration with the Human Resources Director to address the re-allocation of the current MHT staff.

2. The Program Coordinator will followup with the MHT employees in the NEO class to ensure they are assigned appropriately to ensure compliance with the 2:6 MHT ratio.

3. Strategic behavioral Center-Garnerwill be in compliance with the actions on POP by 10/31/2020."

Review on 11/25/20 of the facility's second POP dated 11/25/20 submitted by the DOQC/RM revealed the following:

Note: The professional work titles Chief Nursing Officer (CNO) and Director of Nursing

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V 314	Continued From page 23 (DON) were used interchangeably and refer to the same person. "- *Addendum: Survey was initially closed 10/12/20 and reopened due to complaints on 10/13/20 and closed 11/25/20. Information on this document will be used in addition to information submitted 10/12/20... - What will you immediately do to correct the above rule violation s in order to protect clients from further risk or additional harm? 1) Regarding Therapeutic living environment: Mandatory training for all staff regarding but not limited to Therapeutic Boundaries and rapport with patients; Policy 1800.24 Patient Abuse and Neglect (with an emphasis on employees requirements to report any suspected abuse and neglect to their immediate supervisor or directly to the the Hospital Administrator.) Any staff that has not completed training by the deadline will not be allowed to work. 2) Regarding Coordination of Care: There will be reeducation to all Clinical staff regarding Clinical Services Policy 1200.2. Case Management/Discharge Planning Protocol. Additionally, reeducation in coordination of care will be included to ensure all parties i.e. Clinical, CNO, Compliance Director (if warranted to ensure all proper court processes's are followed), any required court officials, guardians and MCO to be involved with any difficult discharge planning. Additionally, will review this policy or any other related policies for possible revisions. Also, education will provided to Clinical staff on patients and their guardians right to ascertain requested documents from the patient's medical record. - Describe your plans to make sure the above happens, 1) Training/reeducation will occur by but	V 314		

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V 314	Continued From page 24 not limited to documented Town Hall meetings, Healthstream training, and or individualized reeducation with staff. The Human Resource Director will ensure all Healthstream trainings are added and all staff has been made aware and assigned the training modules. Also, the Human Resource Director in collaboration with the Compliance Director will ensure all staff has completed all mandatory trainings with any staff that hs not completed training by said deadline will be removed from the schedule. The Interim CEO (Chief Executive Officer) and the Interim CNO will be updated regarding the status of all trainings. 2) Strategic Behavioral Center-Garner will be in compliance with this POP by 12/14/20" This deficiency constitutes a re-cited deficiency. This facility serves adolescents with psychiatric and behavioral diagnoses. Clients in this report ranged from ages 14-17 with diagnoses inclusive of Post Traumatic Stress Disorder, Disruptive Mood Dysregulation Disorder, Conduct Disorder, Major Depressive Disorder, Attention Hyperactivity Defiant Disorder and Bipolar. Clients at the facility had histories of behaviors such as suicidal ideas and victim/perpetrator of sexual abuse. These behaviors and psychiatric diagnoses warranted a secure residential placement to meet their treatment needs. Between 10/29/20-11/13/20 (16 day span), the facility investigated & substantiated 4 verbal and/or physical abuse cases that resulted in the termination of 4 MHT staff. The facility did not retrain remaining staff at the facility to reduce the risk of the abuse patterns continuing. Although cited in May 2020, the facility continued to meet minimum staffing to client ratio requirements of	V 314		

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V 314	Continued From page 25 2:6 between July and September 2020. Data supported by the agency's internal documentation system referenced as the Matrix concluded no more than 5 consecutive days in which the facility maintained minimum staffing. On average, the facility did not meet the 2:6 or 4 staff per 7-12 staff/client ratio for 60 of the 98 shift opportunities. The facility continued to not supervise clients identified with special line of sight observation. For these incidents, sexual behavior of rape allegation and sexual exposure of private parts were investigated. These occurrences were examples the facility's lack of supervision as well as staffing patterns continued to put the clients at substantial risk of serious harm. Additionally, the facility did not coordinate pre discharge planning with the treatment team of FC #594. FC #594 was discharged from the facility without coordination or knowledge of his treatment team or approval required by the Home LME. The facility initiated FC #594's transfer to another PRTF without knowledge of theguardian. Post discharge request from FC #594's guardian regarding paperwork and access to medical information remained unresolved. This deficiency constitutes a Failure to Correct the Type A2 rule violation originally cited for substantial risk of serious harm. An administrative penalty of $500.00 per day is imposed for failure to correct within 23 days.	V 314		
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.	V 315		

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V 315	Continued From page 26 (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. 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 09/04/20 and 10/05/20 of 11 audited clients' (#625, #675, #692, #709, #717, #756, #767, #768, #769, #729 and #741) records revealed the following examples included but not limited to diagnoses, histories, behaviors and age ranges: -Diagnoses: Bipolar, Oppositional Defiant Disorder, Post Traumatic Stress Disorder, Disruptive Mood Dysregulation Disorder, Depression and Attention Deficit Hyperactivity Disorder. - Histories: Neglect/verbal/physical/sexual abuse, substance abuse, poor social/communication skills, trauma and legal/educational issues - Identified behaviors: Sexualized behaviors both victim and perpetrator, suicidal/homicidal	V 315	*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* V 315 begins here ***a) The procedure for preventing the deficiency and implementing the acceptable plan of correction for the specific deficiency identified.*** A Plan of Protection was implemented on 10/12/2020 to include the following: **What immediate action will the facility take to ensure the safety of the consumers in your care?** The leadership team met to review the current census and the full-time staffing for each shift and each rotation to ensure that we are adequately staffed at our current census level. After re-evaluation of our staffing schedule, it was determined that re-allocation of staffing (e.g. days, nights) was needed to ensure compliance with our 2:6 ratio for all shifts/rotations. Currently, we have 10 MHTs completing New Hire Orientation (NEO) that are completing training this week and will be available to start on the hospital's full-time MHT schedule on 10/19/20. Starting today, all PRTF admissions will be held until we demonstrate for 14 consecutive days that we meet and maintain the 2:6 MHT ratio.	b) 10/31/2020 **10/25/2020** Levels of Observation training completed

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V 315	Continued From page 27 ideations and attempts, anger issues, severe agitation and physical/verbal aggression -Ages: 14-17 years old Review between 09/04/20 and 10/05/20 of the facility's public file maintained by Division of Health Service Regulation for the Statement of Deficencies dated 05/26/20 revealed: -Rule violation regarding Minimum staffing requirement. -The facility provided the following Plan of Protection (POP) "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 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	V 315	Additionally, from 10/21-10/25, mandatory facility wide Level of Observation training to include but not limited to Level of Observation documentation, 1:1 and Line of Sight (LOS) monitoring was provided by VP of Clinical Services & Regulatory Affairs. ***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.*** **Describe your plans to make sure above happens.** The Interim DON will be working in collaboration with the Human Resource Director to address the reallocation of the current MHT staff. The Program Coordinator will follow up with the MHT employees in the NEO class to ensure they are assigned appropriately to ensure compliance with the 2:6 MHT ratio. Strategic Behavioral Center-Graner will be in compliance with the actions on this POP by 10/31/2020. ***d)The title of the person responsible for implementing the acceptable plan of correction*** Director of Compliance/RM & Human Resource Director	

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V 315	Continued From page 28 to include but not limited to maintaining ratio during transitioning patients and maintaining ratio with any special levels of precautions. PRTF (Psychiatric Residential Treatment Facility) 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 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, theleadership 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." Review on 09/21/20 of the facility's care of patient policy effective 10/01/16 revealed the following about Levels of Observation...Line Of Sight	V 315		

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V 315	Continued From page 29 (LOS): "-The patient must be in sight of a staff member at all times and 15 minute checks documented." During interviews between on 09/14/20 and 10/07/20, the Director of Quality Compliance and Risk Management (DOQC/RM) reported: -PRTF was composed of halls 300, 400, 500, 600 and 700. -The MHT (Mental Health Tech) staff/client ratio should be 2:6 -When 7-10 clients were present, 4 MHT staff should be on duty -If the residential hall was short MHT staff, the nurse and/or the Milieu Manager should be utilized for coverage -The facility operated using two 12 hour shifts Blue rotation and Pink rotation Interview on 09/16/20, the DOQC/RM reported the following about the facility's Matrix: -Was an outline of staffing patterns based on 12 hour shifts (7A-7:30P or 7P-7:30A) for the building which consisted of 5 Halls to make up the PRTF. -Document completed by the Milieu Manager daily that identifies census, staffing and special observation requirements of clients by hall. Record review on 09/18/20 of the facility's Matrix between 07/18/20-09/04/20 revealed out of 98 shifts: - 38 shifts in which the staffing pattern of 2 staff per 6 client ratio which mostly included the utilization of a nurse for coverage (examples included but not limited to: 2 consecutive shifts or one day was the average length of time the facility maintained compliance;	V 315		

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V 315	Continued From page 30 10 consecutive shifts or 5 days between 08/20/20-08/25/20 was the longest time frame the facility maintained compliance) -60 shifts did not meet staffing minimum of 2 staff per 6 clients ratio (Note: Some day shifts the nurse was not included into the coverage as she would have been solely responsible for nursing duties) (examples included but not limited to: 07/19/20: 700 hall, 7A-7:30P, 10 clients inclusive of 2 clients line of sight while awake, 2 MHT staff-1 Nurse; 08/17/20: 600 hall, 7P-7:30A, 11 clients inclusive of 2 clients LOS at all times and 1 client LOS while awake, 4 MHT staff with two leaving at 5A-1 Nurse; 09/03/20: 400 hall, 7A-7:30P, 11 clients inclusive of 1 LOS at all times, 3 LOS while awake, 3 MHT staff-0 Nurse; 07/18/20: 300 hall, 7A-7:30P, 6 clients inclusive of all clients required checks every 15 minutes-1 MHT-1 nurse) -Sporadic lack of staffing was noted on all halls on all shifts The following is an example the facility failed to assure adequate staffing numbers on the hall : Review on 10/20/20 of the facility's Matrix on 09/20/20 between 7:30P-7A on the 500 hall revealed: -Client census: 6 -Staffing: 2 (FS #4 until 10P, MHT staff #11 & MHT staff #12) -Special Observations: All client every 15 minutes Review on 10/21/20 of the facility's internal investigation dated revealed the following: -09/20/20 10:23P Email from the HS to the	V 315		

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V 315	Continued From page 31	V 315		

facility's Management team members- At approximately 10P, she was alerted by the Licensed Practical Nurse (LPN) #2 on the 500 hall that FS #4 was asleep in the bin room. As the HS approached, FS #4 was snoring loudly and would not wake up when his name was called. She knocked on the door to awake him. She asked FS #4 to gather his belongings and he did not understand what was asked of him. FS #4 was placed on administrative leave.

-The investigative packet only contained statements by the HS and the LPN #2 assigned to the unit.

During interview on 10/22/20 , MHT staff #11 reported the following:

-The night of 09/20/20, he worked a few hours on the 600 hall before being reassigned to the 500 hall.

-Initially, he was not aware of why he had been switched to the 500 hall. Since that night, he had only been assigned to work the 600 hall.

-On his first night on reassignment on the 500 hall, FS #4 worked with him an estimated hour. During that time FS #4 was in the room where the supply bin was located. MHT #11 staff was in the hallway monitoring the clients. MHT #11 staff did not see FS #4 the remainder of the shift. He had not seen FS #4 since the night of 09/20/20. Thereafter, he did not see FS #4 nor any other staff that night while on duty. The other staff had been reassigned to another hall.

-During the shift, "the nurse" came on the hall but not for a long period of time.

During interview on 10/22/20, MHT staff #12 reported the following:

-She was hired August 2020.

-Some details regarding events of 09/20/20 were "a blur."

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V 315	Continued From page 32 -She did recall three staff assigned on duty that night. She knew FS #4 and herself worked but was not sure of who the third MHT staff would have been. -At some point during the shift, the HS contacted her to have FS #4 come to the telephone. She remembered "him saying for what? I said I don't know. He was upset. He went in the bin room and left." -She was not sure if she remained on the 500 hall that evening for her entire shift. She did ask the nurse on duty what happened regarding FS #4 and was told it was an "administrative" matter. -She confirmed that in the past, she had observed FS #4 sleep while on duty. "It starts out light but heavier during the night as the shift ends." The facility had cameras and could see so she thought others knew. She could not recall if she observed or was aware FS #4 slept the night of 09/20/20. -Since August, she had worked alone on the unit twice. Between 10P-12Midnight, staff may be reassigned to another unit. She was not sure how often she or another staff had been reassigned . During interview on 10/22/20, the HS reported the following: -She had heard from other staff, FS #4 had been sleeping while on duty. She was never able to observe him asleep until the night of 09/20/20. -On 09/20/20, both the Residential Counselor and LPN #2 indicated FS #4 was asleep in the bin room. Upon arrival on the hall, she observed him in the chair snoring and not responding to attempts made to verbally and physically awake him. -She observed MHT staff #11 and MHT staff #12 on the hall. She did not observe MHT staff #12 initially but admitted she did not go all the way down the hall. It wasn't until later that she	V 315		

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V 315	Continued From page 33 observed MHT staff #12. During interview on 10/01/20, the Interim Chief Nursing Officer (CNO) reported the following: -His role was to provide supervision of the Nurses -Facility had "momentarily staffing shortages" on the hall. -Agency utilized other staff such as the PRN (as needed) pool, staff from the non PRTF services and administrators. -Once the client census on the hall reached 7, at least 4 staff should be available on duty. During interviews between 09/15/20 and 09/25/20, the DOQC/RM revealed the following: -She was aware the facility had been cited previously regarding staffing. -The issue with staffing was ongoing. -The agency hired a recruiter in May who focused on MHT staff and (as needed) PRN staff pool -34 MHT staff had been hired between June-September 2020...19 MHT staff had been hired for the PRN staff pool. -Training had been completed for staff regarding the 2:6 ratio requirement prior to July 2020. -As clarification to the previous POP regarding admission of clients during the corrective period-The census and staff/client ratio for that shift at the time of admission on the hall was reviewed to determine if a client would be admitted. 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		

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V 502	27D .0102 Client Rights - Suspension and Expulsion 10A NCAC 27D .0102 SUSPENSION AND EXPULSION POLICY (a) Each client shall be free from threat or fear of unwarranted suspension or expulsion from the facility. (b) The governing body shall develop and implement policy for suspension or expelling a client from a service. The policy shall address the criteria to be used for an suspension, expulsion or other discharge not mutually agreed upon and shall establish documentation requirements that include: (1) the specific time and conditions for resuming services following suspension; (2) efforts by staff of the facility to identify an alternative service to meet the client's needs and designation of such service; and (3) the discharge plan, if any. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop and implement an expulsion policy that addressed discharges not mutually agreed upon as well as did not have a discharge plan for one of three Former Clients (#594). The findings are: Review on 10/15/20 of Former Client (FC) #594's record maintained by the facility revealed the following: -Admitted 03/13/20 -Discharged 07/08/20 -Diagnoses: Conduct Disorder and Cannabis	V 502	*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* V 502 begins here ***a) The procedure for preventing the deficiency and implementing the acceptable plan of correction for the specific deficiency identified.*** A Plan of Protection was implemented on 11/25/2020 to include reeducation to all Clinical staff regarding Clinical Services Policy 1200.2, Case Management/ Discharge Planning Protocol. Additionally, reeducation on coordination of care will be included to ensure all parties i.e. Clinical, CNO, Compliance Director (if warranted to ensure all proper court processes are followed), any required court officials, guardians and MCO to be involved with any difficult discharge planning. Additionally, will review this policy or any other related polices for possible revisions. Also, education was provided to Clinical staff on patients and or their guardians right to ascertain requested documents from the patient's medical record. Policy 1200.2 Case Management/Discharge Planning Protocol was revised to address Coordination of Care for complex discharges. Additionally, the clinical team and the Medical Records Clerk will be reeducated on the guardians right to request and receive medical records.	

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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 502	Continued From page 35 Use Disorder -Age: 15 year old -07/05/20, FC #594 was involved in an altercation with a peer. The peer sustained an injury to his left eye (blacken/swollen) and was taken to the emergency department. Review on 10/27/20 of the facility's discharge criteria revealed "administrative discharge and/or transfer to another setting can be instituted in the following case: Evidence of violent, unsafe or other behavior which cannot be managed within the service." The policy did not address document requirements that included efforts by staff to identify alternative services and discharge plan. Review on 10/15/20 of FC #594's discharge summary signed and dated by the physician at the facility on 07/20/20 revealed the following: -Chief complaint: "Court Ordered." -"Hospital Course:" Admitted to PRTF and "provided with bipsychosocial treatment modality that included individual, group and family therapy as well as medical management and recreational therapy in a controlled environment for psychiatric, residential and academic needs. For much of the time here, he struggled with physical aggression and had numerous incidences of physical restraint for aggression toward staff and peers. He had a very difficult time taking accountability for his negative behaviors. He would frequently refuse medications at time, could be convinced that it was not in his best interest to take them. His moods when I interacted with him were normally stated to be fine, but he had very low frustration and really struggled with aggressive behavior and interpersonal frustration. He would kick off the unit frequently and he was angry." -Discharge Disposition: He was discharged	V 502	***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.*** The Director of Clinical Services (DCS) will inform the CEO and the Director of Compliance/RM of any complex or discharge planning pertaining to any patients that are court ordered for treatment. The DCS will report out in morning meeting the status of any potential discharges and any barriers. 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 ***d)The title of the person responsible for implementing the acceptable plan of correction*** Director of Clinical Services and Director of Compliance/RM V 502 ends here	b) 12/14/2020

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	20140058	A. BUILDING: _____ B. WING _____	11/25/2020

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V 502	Continued From page 36 home with intensive in-home services and medication management. Appointments for these services were set up. Review on 10/15/20 of an employee injury list revealed FC #594 was involved the following in staff related occurrences: -05/13/20- Chest/Face Contusion (Licensed Practical Nurse #3) -05/24/20- Scrotum Contusion (Registered Nurse #2) Review on 10/15/20 of North Carolina Incident Response Improvement System (IRIS) revealed the following incidents between 05/23/20 and 07/08/20 that involved FC #594: -submitted 07/08/20...On 07/05/20 at 4:45P, clients were outside playing kickball, this client kicked the ball. This client asked peer if he liked his kick. When the peer responded he did not care about how the client kicked, this client became upset. The client and his peer exchange words with each other. Peer tried to walk away from incident but then turned back around so not to be hit in the back of the head by this client who walked behind peer. Punches were exchanged but no one was hit. The two wrestled to the ground and this client was placed in a restrictive intervention until other peers were transitioned out of the courtyard. -submitted 07/08/20...On 07/05/20 at 5:59P...Client was in the gym paying ball with his peers and as per staff he was discussing about the prior incident that happened in the courtyard and staff was telling him about his behaviors and he became upset and kicked off the gym. As soon as he was coming back on the unit he saw the boys on 600 sitting in the hallway, this client "jumped at the nursing station, opened the door and went to the hall and punched a peer on the	V 502		

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V 502	Continued From page 37 face and opened the door, jumped back on the nursing station and went back to the cafeteria hallway. Staff was trying to de-escalate him while he was in the cafeteria, but he became more aggressive, they were able to convince him to walk back to 500-600 (hall), but he was still aggressive and wanted to go back to 600 (hall), he was swinging at everybody (that was) trying to redirect him. It was a struggle before staff was able to restraint him, he spit on the Supervisor's face and threaten to kill him." -submitted 07/11/2020...On 07/07/20 at 6P, Client "would not program with the rest of his peers. He was just looking for any excuse to fight. He tore the complaint box off the wall on the nurse's station. He went outside the 800 (hall) and had a ruckus going on and when peer came through, he started jeering and taunting him when he was already angry. Staff asked him to move away from the door and that's when he started to kick the door trying to break it.... started to spit on staff and call him names and threaten to kill his mama, children... took off running after somebody on the courtyard and staff stopped restrained him." - No evidence of IRIS reports 05/13/20 or 05/24/20 involving FC #549 in which staff were injuried. Refer to V314 Example IV for more specifics regarding FC #594's discharge. The example outlines specifics regarding the lack of procedures and processess such as coordination of services and supporting documents utilized when this client's services were terminated by the facility. During interview on 10/20/20, the Director of Quality Compliance & Risk Management (DOQC/RM) revealed the following:	V 502		

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V 502	Continued From page 38 -This was the only policy the facility had regarding discharge and expulsion of services -She was not involved in the specifics regarding FC #594's discharge but was aware it was an emergency. The facility could no longer meet his needs and he had injuried staff and clients.	V 502	*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) 1/24/2020
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable	V 537	*V 537 begins here* ***a) The procedure for preventing the deficiency and implementing the acceptable plan of correction for the specific deficiency identified.*** The Patient Safety Committee is comprised of Nursing Management, Clinical Services, CPI Instructor, Compliance Director, and Patient Advocate. All restrictive interventions are reviewed. Any identified issues to include techniques are documented with an action plan for immediate follow up. If additional CPI training is warranted the CPI instructor will provide the necessary training. Additionally, the Human Resource Director will conduct an internal audit to ensure all necessary staff members are trained in CPI. ***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.*** To ensure compliance, 100% of the restrictive interventions are reviewed with any issues reported out in morning meeting and a report provided to the CEO, The Human Resource Director will conduct an internal audit of all personnel file for CPI compliance with concurrent audits completed quarterly.	

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V 537	Continued From page 39 methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and	V 537	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 ***d)The title of the person responsible for implementing the acceptable plan of correction*** Interim CNO, Human Resource Director and the CPI Instructor V 537 ends here	

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V 537	Continued From page 40 (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule.	V 537		

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V 537	Continued From page 41 (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interview, facility staff failed to demonstrate competency in	V 537		

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V 537	Continued From page 42 procedures.This affected 3 of 13 audited Mental Health Tech staff (#13, #2, #3) and 1 of 5 former audited staff (#5). The findings are: During interview on 10/23/20, Director of Quality, Compliance & Risk Management (DOQC/RM) reported: -The facility transitioned from using Handle with Care to using Non Violent Crisis Intervention (CPI) -The transition date changed from February 2020 to March of 2020 "But Covid hit and they couldn't start" -All staff had been trained in CPI A. During interview on 10/22/20, Lead Mental Health Tech (MHT) staff # 13 reported he: -Had performed a single person restraint on 10/11/20 -Grabbed client #782 from behind -Client "head butted" and lost footing, stumbled and fell with the client into the wall -Used a single person restraint/technique that was taught in a previous training Handle with Care -Facility phasing out the use of Handle with care and adopting the use of CPI -Currently trained in CPI -Can't remember when the facility switched over to crisis intervention program. -Was retrained (CPI) before returning to work. During interview on 10/23/20, Client #782 reported he: -Was slammed against the door -Was thrown into the wall and didn't fall -Didn't remember MHT staff #13 called him any inappropriate name -Had kicked off the hall, was restrained when	V 537		

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V 537	Continued From page 43 kicked off (kicked through the doors) During interview on 11/23/20, Facility's CPI instructor reported: -Facility had trained all staff in CPI -Facility was previously trained in Handle With Care and switched to CPI in February 2020 -CPI had a single person hold for a smaller child not preferably used on a teenager or adult. B. During interview on 11/12/20, Former MHT staff #5 (FS) reported: -Had been trained in CPI when hired 05/2020 -Client touched his hair, did not remember a technique in CPI when someone approached from behind or when someone pulls your hair -He turned around grabbed the client #675 and shook him. -Acknowledged that was not a CPI technique. During interview on 11/23/20, Facility CPI Instructor reported: -CPI does have a technique for touching hair, a technique for hair pulling and de-escalation -You can always walk away from a client for de-escalation -Staff were trained in CPI during new hire orientation. -Pushing a client is not a CPI technique. During interview on 11/19/20, Facility Maintenance staff reported: -Had worked on a door on the hall -Witnessed FS #5 push client to the floor -Didn't hear cursing or threats toward client #675 Several attempts made to interview client #675 during the survey. Client #675 refused to interview with surveyors.	V 537		

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V 537	Continued From page 44 C. Review on 11/23/20 of the facility's video surveillance revealed: -Date of the incident 11/02/20 -FS #4 and MHT staff #3 entered the room with client #741 in a 2 person restraint. -45 seconds into the video, MHT staff #2 entered the room and assisted with the restraint, when client started to kick -1 minute 56 seconds into the video MHT staff #3 grabbed and lifted client #741 by the legs which resulted from him going from a standing position to a seated position on his buttocks on the floor. MHT staff #2 and FS #4 went down to a seated position on the floor. Review on 11/23/20 of the CPI facility's manual revealed: -There is no restraint swooping someone's feet from underneath them to change posture from standing to seated. During interview on 11/23/20 Facility CPI Instructor reported: -Was not a part of the Safety meeting that reviewed this incident -In Preparation for this interview on 11/23/20, he reviewed 11/02/20 video -CPI had not shown how to get a client on the floor. -In CPI clients sit down on their own -CPI does not teach a staff initiated technique to transition a client from standing to a seated position to the floor -Facility had trained all staff in CPI since February 2020 -Not aware of any recommendations from safety meeting for the client to be transitioned from standing to seated on the floor.	V 537		

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V 537	Continued From page 45 During interview on 11/23/20 DOQC/RM reported: -Had reviewed the incident dated 11/02/20 facility video -Concerned how the client was transition to the floor -Clients were supposed to initiate the seated position to the floor -Techniques were not identified during the review at safety meeting During interview on 11/20/20 MHT staff #3 reported: -During restraint clients are usually asked to sit -During the restraint MHT staff #2 grabbed and lifted client #741 by the legs which resulted from him to go from a standing position to a seated position on his buttocks on the floor. -Doesn't recall grabbing and lifting leg technique being taught in CPI	V 537		

STRATEGIC
BEHAVIORAL CENTER

December 15, 2020

NCDHHS/DHSR
India Vaughn-Rhodes, Facility Compliance Consultant 1
Keisha Douglas, Facility Compliance Consultant 1
1800 Umstead Drive
Williams Building
Raleigh, NC 27603

RE: Follow Up and Complaint Survey completed November 25, 2020. Intake #NC00169584, #NC00169289, #NC00171503, #NC00171347, #NC00171346, #NC00170657, #NC00170658, #NC00170616, #NC00169584, #NC00168370, #NC00171587, #NC00170650 and #NC00170422

Dear Mrs. Vaughn-Rhodes & Keisha Douglas:

Enclosed is the A2 and Standard Level of Deficiencies Plan of Correction that I am submitting on behalf of Strategic Behavioral Center-Garner.

Respectfully,

James Wilfer, Interim CEO

Enc: Plan of Corrections

qsj

3200 Waterfield Drive • Garner, NC 27529
(919) 800-4400 • Fax (919) 573-4163

2050 Mercantile Drive • Leland, NC 28451
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