STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20140058	A. BUILDING: _____ B. WING _____	C 03/26/2021

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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 complaint and follow-up survey was completed on 3/26/21. The complaints were substantiated (Intake #NC00172482, NC00171457, NC00173236). The complaints were unsubstantiated (Intake #NC00173339, NC00173637, NC00173216, NC00173116, NC00172738, NC00172105, NC00174828, and NC00173666). Deficiencies were cited. This facility is licensed for 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) 5/20/2021*
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug;	V 118	*V118 starts here* ***a) The procedure for preventing the deficiency and implementing the acceptable plan of correction for the specific deficiency identified.*** ***The facility failed to ensure medications were administered on the written order of a physician affecting 2 of 8 audited clients (#3544, #7624) who were reviewed for medications.*** On March 15, 2021, the facility went live with our Electronic Medication Administration Record (eMAR). This feature requires the electronic documentation of medications consistent with physician's orders. Variances are created if a medication is administered that is different than the order the Pharmacist will be alerted and will create a variance report that is submitted to the CNO for follow up and corrective action as warranted.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Evelyn Allsop — TITLE: CEO — (X6) DATE: 4-23-21

DHSR - Mental Health
APR 26 2021
Lic. & Cert. Section

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V 118	Continued From page 1 (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure medications were administered on the written order of a physician affecting 2 of 8 audited clients (#3544, #7624) who were reviewed for medications. The facility failed to ensure the MAR was kept current for 3 of 8 audited clients (#3780, #3544, #7624) who were reviewed for medications. The facility also failed to ensure 3 of 4 audited staff (Licensed Practical Nurse (LPN) #1, Mental Health Technician Staff (MHT) #1, and MHT Staff #3) demonstrated competency in the administering of medication affecting 3 of 8 audited clients (#7680, #7414, #2097) who were reviewed for medications. The findings are: 1. The following is an example of how medications were not administered and MARs not kept current: A. Review on 3/11/21 & 3/12/21 of client #3780's record revealed: -Admitted 7/14/20 -13 years old -Diagnosis: Disruptive Mood Dysregulation	V 118	Additionally, a review of policies related to medication administration was conducted during the April Nurses' meeting. Policies included Medication Preparation and Administration, Medication Variances, and Informed Consent for Medication. Policy review will be completed by 5/20/2021. to validate 100% review by all nurses. A review of job duties and responsibilities for nursing personnel (i.e. Registered Nurse, Licensed Practical Nurse) to be conducted during May Nurses' meeting. Emphasis will be placed on medication administration as a job responsibility of the registered nurse and LPN with emphasis on the physician or LIP as the prescribing authority. ***The facility failed to ensure the MAR was kept current for 3 of 8 audited clients (#3780, #3544, #7624) who were reviewed for medications.*** *A 24-hr. chart check policy will be implemented requiring documentation of variances to be reported to the CNO. If no variances are reported the form will still be required to indicate no variances, and the CNO will check validation to ensure the forms are completed accurately. The CNO will provide education on the new policy during the May nurses' meetings.* *Additionally, a review of policies related to medication administration was conducted during the April Nurses' meeting. Policies included Medication Preparation and Administration, Medication Variances, and Informed Consent for Medication. Policy education will be completed by 5/20/2021. to validate 100% review by all nurses*	

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V 118	Continued From page 2 Disorder (DMDD) -12/27/20 physician order Thorazine (antipsychotic medication)100 milligram (mg) IM (Intramuscular) and Benadryl (for behaviors) 50mg IM -12/2020 MAR did not reflect above medications were given on 12/27/20 Interview on 3/1/21 & 3/10/21 with the House Supervisor/Registered Nurse (HS/RN) #4 revealed: -She did see Thorazine 100 mg and Benadryl 50 mg on client #3780's physician order dated 12/27/20 but did not see it on the 12/2020 MAR B. Review on 3/11/21 & 3/12/21 of client #7624's record revealed: -Admitted 9/01/20 -17 years old -Diagnoses: Post traumatic stress disorder (PTSD), Bipolar disorder (d/o) unspecified history (hx), rule out (r/o) disruptive behavior d/o, Attention-Deficit/Hyperactivity d/o (ADHD) by hx, Oppositional Defiant d/o (ODD) by hx -2/2021 MAR listed: Divalproex sodium ERT 750 mg oral at bedtime for mood, trazodone tablet 50 mg oral at bedtime for sleep, Neosporin apply to back twice daily -Physician's order dated 2/17/2021:Thorazine 100 mg IM & Benadryl 50 mg IM (for behaviors) -Restraint packet dated 2/17/21 revealed Thorazine 100 mg IM and Benadryl 50 mg IM given at 7:23pm -2/2021 MAR does not reflect above medications given on 2/17/21 -2/2021 MAR Neosporin had circled initials and no explanation on the 19th at 8:00pm, 20th - 23rd at both 8:00am & 8:00pm -3/2021 MAR had a blank space on the 4th at 8:00pm for Divalproex sodium ERT and	V 118	**The facility also failed to ensure 3 of 4 audited staff (Licensed Practical Nurse (LPN) #1, Mental Health Technician Staff (MHT) #1, and MHT Staff #3) demonstrated competency in the administering of medication affecting 3 of 8 audited clients (#7680, #7414, #2097) who were reviewed for medications.** *A review of job duties and responsibilities descriptions for nursing personnel (i.e. Registered Nurse, Licensed Practical Nurse, and Mental Health Techs) to be conducted during May Nurses' meeting. Emphasis will be placed on medication administration as a job responsibility of the registered nurse and LPN that cannot be delegated to the MHT.* *Additionally, a review of policies related to medication administration was conducted during the April Nurses' meeting. Policies included Medication Preparation and Administration, Medication Variances, and Informed Consent for Medication Policy education will be completed by 5/20/2021. to validate 100% review by all nurses.*	

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V 118	Continued From page 3 Trazodone tablet 50 mg Interview on 3/1/21 & 3/8/21 LPN #2 reported: -Employed since 7/2020 -Clarified why IM injections for Thorazine 100 mg and Benadryl 50 mg for client #7624 were not listed on the MAR for 2/17/21 -It was "human error" that she did not write the order or fill out and initial the MAR -It was just this time that it happened -There was a lot going on with shift change, incident reports etc that she didn't fill it out and it was "my mistake" C. Review on 3/12/21 of client #3544's record revealed: -Admitted 11/24/20 -15 years old -Diagnosis is DMDD -12/27/20 physician order: Thorazine 100 mg IM & Benadryl 50 mg IM -12/2020 MAR had no documentation these medications were administered on 12/27/20 -Incident Response Improvement System (IRIS) dated 2/17/21 revealed Thorazine 100 mg & Benadryl 50 mg IM were administered -Facility Health Incident Review Packet dated 02/17/21 revealed Thorazine & Benadryl "injections were ordered and administered" -2/2021 MAR had no documentation that Thorazine or Benadryl was administered -No physician order on 2/17/21 for Thorazine or Benadryl IM Interview on 3/1/21 & 3/10/21 HS/RN #4 revealed: -She did see Benadryl 50 mg and Thorazine 100 mg on client #3544's physician order dated 12/27/20 but did not see it on 12/2020's MAR -Didn't see where IM medications were given to	V 118	***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.*** Weekly audit of the medication administration process will begin 5/1/202 and will continue until implementation of the electronic health record in September 2021. The audit will review a random selection of physician orders for 30% of census in comparison with the documentation in the electronic medication administration record. For a census of less than 20 residents, 100% review will occur weekly. Notification of medication variances will occur consistent with hospital policy. Variances are reviewed bi-weekly with CNO and Director of Pharmacy and reported during monthly Quality Assurance Performance Improvement meetings. These findings are being presented at the Hospital's Morning Meeting on a weekly basis. A summary of the findings is being forwarded to the Quality/PI Council, Medical Executive Committee and Governing Board at each of their respective meetings. ***d)The title of the person responsible for implementing the acceptable plan of correction.*** *Chief Nursing Officer, and Director of Pharmacy* V118 ends here	

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V 118	Continued From page 4 client #3544 on 2/17/21 on the MAR but did see where it was listed on the restraint packet that it was ordered and administered Interview on 3/22/21 the facility's Director of Pharmacy reported: -Verified there were no physician orders for Thorazine 100 mg & Benadryl 50 mg IM for client #3544 in 2/2021 -She didn't see any IM medication on client #3544's physician order form in 2/2021 -There was an emergency lock box that the nurses can pull from to get the medication but they needed to note it in the chart and on MAR -Didn't keep a log in the pharmacy because those meds are available on the units -LPN #2 told her that a verbal order was obtained from the doctor but she forgot to make note of it -LPN #2 put it in the file as a late entry -Does not get a copy of the restraint packet to know that an injection had been given -The only way the pharmacy knew if an IM medication had been given is if the count is different whenever they did a count -There is no set schedule for conducting a count Interview on 3/22/21 the Assessment & Referral Specialist reported: -Was previously the Interim Chief Nursing Officer (CNO) for the past 9 months until 2/2021 -While acting in this role he oversaw the nursing department & MHT's -24 hour chart checks were done by the floor nurse assigned to the unit that night -There were multiple things the nurses checked for, one being physician orders against MARs -If something was initialed on the MAR but not written on the order, the nurse would "red flag" it -It would then be added to the shift report of things they found for the HS/RN to follow up	V 118		

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V 118	Continued From page 5 Interview on 3/23/21 CNO reported: -Started in this role on 2/1/21 -The first 2 weeks she was in orientation -Responsible for all nursing services 24/7 -Blank spaces on the MAR was an error because if it wasn't available it should be listed on the back of the MAR -If there was a documentation error, she would speak with the nurse and tell them to document it and let them know the MAR should be filled out thoroughly to avoid a lot of questions being asked -If the medications are there and just not given, that's a counseling to find out the reason why Interview on 3/1/21 & 3/8/21 LPN #2 reported: -If a medication was not available or a client refused the medication, the nurse circled their initials on the MAR -An explanation of the circled initials was written on the back of the MAR Interview on 3/1/21 & 3/10/21 HS/RN #4 revealed: -Worked at facility for 7 years -MARs are reviewed every night by the nightshift nurse on duty which is known as a 24 hour chart check -One of the tasks of a chart check is to reconcile MARs with the physician orders -Circled initials on an MAR means there should be an explanation on the back of the MAR of why initials are circled -There should not be any blank spaces on the MAR and if there are, that would be an error -It should have been reconciled during the nightly chart review -When HS/RN's are made aware of something not being documented correctly, they follow up to see if the medication has been ordered on the	V 118		

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V 118	Continued From page 6 physician order and from the pharmacy first -Couldn't follow up with something if they didn't know about it -If a verbal order was given, it would be faxed to the pharmacy and if they administered the drug it needed to be documented on both the MAR and physician's order -When there are a list of items that are missing from the physician order and/or MAR, it's written down by the night nurse that does the 24 hour check for the morning shift to follow up on -The list goes to the CNO for their records and follow up -Nurses get trained on documentation every 6 months and at the annual inservice training -Training included medication orders, transcribing orders, giving an injection or as needed medication (PRN) and what to do with it and checking for effectiveness, what to do when you don't give a drug and how it's written on the back of the MAR -A trend is a reason for re-training and she saw a trend with documentation -The nurses involved will need to be retrained -All nurses across the board will be included in the training to prevent some of the documentation errors Due to failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician. 2. The following is an example of how LPN #1 and MHT #1 & #3 failed to demonstrate competency in the administering of medication. A. Review on 2/9/21 & 2/23/21 of client #2097's record revealed: -Admitted 7/10/20	V 118		

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V 118	Continued From page 7 -15 years old -Diagnoses: DMDD, ADHD by Hx, r/o PTSD, r/o Bipolar d/o, r/o Thought d/o, Borderline Intellectual Functioning B. Review on 1/27/21 of client #7414's record revealed: -Admitted 8/1/20 -14 years old -Diagnoses: DMDD, r/o depression, Attention-Deficit/Hyperactivity d/o by hx, seasonal allergies and possible anemia C. Review on 2/1/21 of client #7680's record revealed: -Admitted 9/4/20 -16 years old -Diagnoses: DMDD, ODD, Generalized Anxiety d/o Review on 2/4/21 of facility's concluded investigation dated 12/31/20 revealed: -Email from the Director of Compliance/Risk Management to CNO with a cc to the Chief Executive Officer (CEO) -"Below is the conclusion from the Nurse investigation...This is a serious issue that needs to be address. CNO, I will leave this in your capable hands." -"In regard to the incident of [LPN #1], nurse, giving patient meds (medications) to non-medical staff she stated she did do so. [LPN #1] stated on the morning of 12.29.2020 she ran out of time to pass the 6:30am meds to [client #2097] and [client #7680], 600 hall patients, [LPN #1] stated she was busy with checking the fridge temp (refrigerator temperature), checking for expired meds and cleaning the med room. Therefore, she handed 2 MHT's, [MHT #1] and [MHT #2], 1 med cup each to pass to 2 separate patients.	V 118		

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V 118	Continued From page 8 [MHT #2] stated [LPN #1] called her over and asked her to pass the meds to a patient. [MHT #2] stated she was not comfortable, so she gave the cup to [MHT #1]. [MHT #1] had already passed the med that was given to her by [LPN #1]. I could not reach [MHT #1]. [Client #2097] confirmed that [MHT #1] gave him meds and that he was not asked to come to the med room window. He stated his mouth was not checked after he took the meds, either." -CEO stated in a response to this email "[Assessment & Referral Specialist (Interim CNO)], asap (as soon as possible) with corrective action for both nurse and MHTs. Let me know when this has been resolved." Review on 3/2/21 of LPN #1's training dated 2/11/21 revealed: -Conducted by the Infectious Control Nurse -Reviewed Medication Preparation and Administration policy -Reviewed the process of administering medications Review on 3/5/21 of the 30 day Medication Pass Tracking Log for LPN #1 dated 2/4/21 revealed: -Conducted by HS/RN #1 -Observe for 30 days -Observation started 2/4/21 Review on 3/3/21 of MHT #1's Facebook social media post revealed: -"So I reported a nurse today, I'm at a psych facility and she has been giving the techs the meds to give to the children. I walked in a room with her to spot her and she woke the child up put the meds in my hand and walked out. I gave the child the meds because he was up looking at me which I know I shouldn't have. I felt so guilty and bad so I reported her because what if someone	V 118		

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V 118	Continued From page 9 give the kids the wrong meds or take the meds for themselves I mean anything. She should walk her lazy behind on the hall and pass out the meds" Interview on 2/5/21 client #2097 reported: -Believed his discharge was 2/25/21 -Received his medication every day from the nurse -One time an MHT (MHT #1) gave him his 6:00am medication without a nurse (LPN #1) present -He asked where the nurse was and MHT #1 said that the nurse was at the dock station -He didn't know the name of the medications but knew what they looked like -It was 2 pills (a white pill and an orangish red pill) -That MHT #1 also gave client #7680 his medication right after she gave him his medication -Client #7680 room was diagonal from his room -He wrote an incident report to the Patient Advocate because he knew the nurse was supposed to give him his medication Interview on 2/5/21 client #7414 reported: -He has a room to himself on the 600 Hall -The nurse gave him his medication -No other staff had given him his medication Interview on 2/5/21 client #7680 reported: -The nurse gave him his medication -No one other than the nurse had ever given him his medication Interview on 2/11/21 MHT #1 reported: -Worked PRN 3rd shift 7pm - 7am -Employed since 11/2020 -Not medication trained -Nurses are the only ones that gave medications	V 118		

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V 118	Continued From page 10 -Denied ever giving any client medication, but did report LPN #1 for trying to give her medication to give to client #2097 -LPN #1 tried to wake client #7414 up and the nurse handed her the cup of medication and water -When client #7414 woke up, LPN #1 said give him his medicine and she refused -That she witnessed this has happen before with LPN #1 giving MHT staff #3 medication to give to client #7414 -Both of these incidents happened around Christmas 2020 Interview on 2/18/21 & 3/3/21 Former Registered Nurse (RN) reported: -Worked 7pm-7am shift -Direct supervisor was HS/RN #3 -Last day of employment was 2/15/21 -MHT #1 told her that LPN #1 handed her client #2097's medicine and had her give it to him -She told MHT #1 not to do that again -MHT #1 posted it on social media -Client #2097 told her that MHT #1 handed him his medication -This prompted her to ask client #7414 if anyone other than a nurse gave him his meds -Client #7414 told her that he didn't want to get anyone in trouble but it was MHT #3 that gave him his meds -MHT #3 told her that she administered medication to client #7414 -MHT #3 told her that she didn't know what the medication was that she gave the client -She told HS/RN #3 what MHT #1 told her and she was advised to send an email to "the powers that be" -She reported the incident to Director of Risk Management and CEO	V 118		

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V 118	Continued From page 11 Interview on 2/19/21 & 3/3/21 MHT #3 reported: -Employed at the facility since 10/2020 -Worked 7am - 7:30pm -Her job does not require her to administer medication -Nurses administer medication -Initially denied ever being asked by a nurse to administer medication to a client but then stated there was one time in which she did -This was sometime in 12/2020 -It was a "hall brawl" (fight) and the nurse was trying to get to client #7414 to give medication but couldn't -The nurse handed the medication to her and she gave the medication to client #7414 -She didn't know the nurse name but said that it was an African American nurse -It was 2 - 3 pills in the cup -She thought that one of the pills given to client #7414 was Vistaril -She didn't know what the other medications were for -A staff came to her later and asked if she gave a client medication and she said no -She did not know the staff -She did not know that she was not supposed to give the pills to client -No one from management had spoken to her in regard to the incident Interview on 3/1/21 MHT #2 reported: -Employed almost 3 years -Worked 7pm - 7:30am -MHT's were not allowed to administer medication -She was asked to administer medication by LPN #1 -She did not feel comfortable giving medications and gave them to MHT #1 to give and LPN #1 just nodded and said okay	V 118		

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V 118	Continued From page 12 -MHT #1 must have felt comfortable because she was already en route to client #2097 to administer medication -She did not see MHT #1 give the medication to client #2097 -Any time medications are given, there was a "spotter" to watch -She spotted MHT #1 giving the medication to client #7680 -She didn't remember how many pills were in the cup -Medication passes are normally given at the window by a nurse and a MHT was present to observe -If a client was not feeling well and the nurse went to the client's room, an MHT would go and observe -She did not let anybody know about this incident -She was not sure when this happened (maybe after New Year) Interview on 3/1/21 LPN #1 reported: -Employed since 10/2020 -Worked 7pm-7am -She gave medication to an MHT to give to a client (thinks it was client #2097) -She was trying to get all the end of the month tasks together and was running out of time (has a timeframe to complete) to get it done and she poured medication in a cup to give the client -She called one of the MHT's (MHT #1) to give the medication to client #2097 and bring the cup back to her (don't remember the MHT's name) -1 pill was in the cup (Synthroid - thyroid medication) to give to client #2097 -The MHT gave the medication and brought the cup back to her to confirm the medication was given -She signed the MAR for the medication that was given by the MHT	V 118		

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V 118	Continued From page 13 -She received a call from the Patient Advocate after this incident saying that there was an issue with the medication -She was told that she is not supposed to give any medication to the MHT's to give to client's -She needed to be re-trained -She was not sure if the client actually took the medication because she was not there but the cup was brought back to her empty -She was written up and re-trained for one day on medication and medication policies Interview on 3/1/21 Infectious Control Nurse reported: -She is also an Educator -Been at facility for 8 years -Been in this role since 3/2020 -She received an "urgent" email around 2/6/21 that LPN #1 gave medication to an MHT to administer to a client and needed to be re-trained -A Performance Improvement Plan (PIP) was put in place on 1/27/21 -She did extensive training with LPN #1 on medication administration that started around 2/14/21 Interview on 3/1/21 CEO reported: -Interim CEO since 10/2020 "maybe the 5th" -Director of Compliance/Risk Management sent him an email on 12/31/20 about the incident with LPN #1 -His concern was that he didn't know if the client received the medication and that it was not the MHT's job -It was not the the role of the nurse to give the medication to an untrained staff -He sent an email to the Interim CNO on 12/31/20 before he went out on sick leave to take a look into this incident and follow up with him when he returned	V 118		

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V 118	Continued From page 14 -He was away from the facility, Dec. 31st and returned Jan. 11th due to illness -He was told that Human Resources (HR) revisited the incident with LPN #1 Interview on 3/17/21 Patient Advocate reported: -Employed almost 3 years -Responsible for investigating grievances, complaints, and allegations -She received incident report regarding LPN #1 on 12/30/20 from Former RN -She started the investigation on 12/31/20 with staff and clients -The completed investigation was then forwarded to Director of Compliance/Risk Management and CEO -The Interim CNO was notified to take necessary steps Interview on 3/22/21 with the Assessment & Referral Specialist reported: -He was made aware of the incident involving LPN #1 by the Director of Compliance/Risk Management but didn't remember when he was told -There was no injury and the right medications were distributed so he had her get re-educated on the medication policy -He initially did a corrective action/write up -Corporate became involved and said that wasn't enough and placed her on a PIP -Part of the PIP involved HS/RN #1 monitoring LPN #1 medication passes to the clients -Did not remember receiving an email from the CEO in regards to this incident Interview on 3/23/21 Director of Human Resources reported: -LPN #1 received a corrective action plan (1st date of follow up is 60 or 90 days depending on	V 118		

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V 118	Continued From page 15 situation) then there is a 6 month follow up following the date of the PIP Interview on 3/23/21 Director of Compliance/Risk Management reported: -She was concerned that a licensed nurse gave an unlicensed staff medication -"Something of this magnitude should have been followed up on before a month later so that was not the usual"	V 118	*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.*	
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	V 314	V314 starts here. ***a) The procedure for preventing the deficiency and implementing the acceptable plan of correction for the specific deficiency identified*** 1) On 3/26/2021, to ensure the safety of the current patients in our care all medical records were reviewed by the Director of Clinical Services (DCS), and Chief Nursing Officer (CNO) to ensure the coordination of care for all patients to include but not limited to, address medication issues including validation of appropriate consents; ensuring residents with medical issues have updated treatment plans to reflect care provided including diagnostic or laboratory studies as needed. Ensuring that all services provided are accurately documented in the medical record. 2) Documented morning rounds were implemented with the CNO or designee and the DCS or designee by 3/29/2021, to evaluate coordination of care regarding any updates or changes in patient condition and follow up to ensure any family notifications are made, as well as updating the plan of care as indicated, as evidence by ensuring patients with medical problems have h plans to address those issues. Each nurse and therapist will have to give a brief report of their residents to include the above information. The DCS and CNO will validate via medical record review that identified issues have been updated.	b) 4/26/2021

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V 314	Continued From page 16 individuals and agencies within the child or adolescent's catchment area. (g) The PRTF shall be accredited through one of the following; Joint Commission on Accreditation of Healthcare Organizations; the Commission on Accreditation of Rehabilitation Facilities; the Council on. Accreditation or other national accrediting bodies as set forth in the Division of Medical Assistance Clinical Policy Number 8D-1, Psychiatric Residential Treatment Facility, including subsequent amendments and editions. A copy of Clinical Policy Number 8D-1 is available at no cost from the Division of Medical Assistance website at http://www.dhhs.state.nc.us/dma/. This Rule is not met as evidenced by: Based on record review and interview the facility failed to coordinate with other individuals and agencies for five of five audited clients (#2238, #7624, #5101, #7347 and #7680) who were reviewed for coordination concerns. The findings are: 1. The following are examples of how the facility failed to coordinate services for clients with special medical needs: Record review on 1/28/21 of client #2238's record revealed: - 15 years old - admitted on 5/29/20 - diagnoses of PKU (Phenylketonuria), Oppositional Defiant Disorder (ODD) and Attention Deficit Hyperactivity Disorder (ADHD)	V 314	This information will be reported out daily in morning meeting with the Leadership team. 3) Current policies pertaining to coordination of care to include but not limited to request for information, patient and family education, and treatment team processes are being reviewed, revised and or created to ensure compliance with 10A NCAC 27G.1901(f). Staff are being educated on all policy and procedural changes. 4) By 4/5/2021, re-implementation of the discharge checklist to ensure all coordination of services has occurred. The Admissions checklist will also be re-implemented to include but not limited to patient orientation, receipt of updated patient handbook to include the process for requesting Medical/School Records including the timeframe (no more than 30 days) for receiving requested information unless otherwise indicated in the correspondence; a welcome letter to include names and contact information for team members. This will also include expectations regarding timeliness in communication with families (i.e., calls to be returned within 48 hours)." ***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.*** 1). Clinical and Nursing services will audit all current PRTF patient charts to ensure coordination of services are occurring as per 10 A NCAC 27G.1901(f). The finding is being charted and reviewed in morning meetings starting 3/29/2021. 2). Morning rounds will begin 3/29/2021 by the CNO and DCS or designees and results will be reported out in morning leadership meetings on the following day with any identified issues and or resolutions. The House Supervisor (HS) will complete weekend rounds and report out to the Administrator on Call (AOC)." "Strategic Behavioral Center-Garner will be in compliance with the actions on this POP by 4/26/2021."	

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V 314	Continued From page 17 - admission assessment dated 6/1/20: "dietician will need to be closely involved due to his (client #2238) dietary needs"...signed by facility's psychiatrist - physician order dated 5/29/20: Phenex (PHE) (amino acid modified powdered medical food is a nutrient specifically designed for children with PKU) 90 grams twice a day at 8am & 2pm A. Review on 2/15/21 of the facility's PKU diet guidelines for client #2238 revealed: - PKU is caused by an inborn error of metabolism. The individual cannot metabolize the amino acid PHE. Review on 1/28/21 of the facility's Multidisciplinary Treatment Team meeting dated 11/25/20 revealed: - "[client #2238's] dad expressed concerns that [client #2238's] protein shakes that are prescribed for his PKU have not been administered correctly ... [CNO] (chief nursing officer), was unable to join the meeting, but [clinical director] stated that she would ask [CNO] to call [dad] when he is available...[dad] shared that due to the difficulties meeting [client #2238] medical needs with his PKU, was another reason he was wanting [client #2238] to be transferred to another PRTF (psychiatric residential treatment facility) ..." - Continued review on 1/28/21 revealed several updates to client #2238's treatment plan (5/20/20; 6/9/20; 7/8/20; 8/3/20; 9/1/20; 9/30/20) to address the following behaviors: - client #2238 gets agitated easily - verbally & physical aggressive toward staff and peers and has difficulty controlling his anger - physician notes client #2238 presents as irritable and impulsive - can be explosive and struggles with coping skills	V 314	3. The results of the audits will be tracked and maintained by the CNO or designee. These findings are being presented at the Hospital's Morning Meeting (Monday -Friday). A summary of the findings is being forwarded to the Quality/PI Council, Medical Executive Committee and 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 & Chief Nursing Officer* *V314 ends here*	

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V 314	Continued From page 18 - punching and kicking walls Review on 3/15/21 of the facility's dietician assessments for client #2238 revealed: - 3/9/21: weight: 147 pounds and height 64 inches (5'4 tall) Review on 3/18/21 of an outside metabolic dietician office visit dated 9/20/19 for client #2238 revealed: - she had treated since newborn for PKU - last office visit 9/20/19 - history of significant behavior issues - 180 grams of Phenex twice a day - weight 87 pounds (lbs)...height: 5'1 inches tall - growth and weight gain appropriate - signed by metabolic dietician Review on 3/22/21 of a note dated 9/25/20 from the outside metabolic dietician's office for client #2238's revealed: - "Based on conversation by our RD (registered dietician) their concern about [client #2238] not receiving adequate medical beverage at the facility he has been at in Garner....(I was) transferred to Strategic Behavioral Center-Garner [SBC-G] psychiatrist]. I discussed and emphasized the need for the facility to communicate with our metabolic dieticians if they have any questions about his dietary restrictions and making sure he gets prescribed amount of medical beverages...discussed poor compliance in the past has resulted in his cognitive delays...he will convey to the medical team and get back with us if there are additional questions..." (signed by a physician) Review on 2/19/21 of client #2238's February 2021 MAR (medication administration record) revealed:	V 314		

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V 314	Continued From page 19 - February 4th at 2pm - February 9 staff initials were circled - no documentation of why staff initials were circled on the MAR Review on 3/15/21 of a nurse note dated 1/27/21: ...:"[client #2238's dad] was called...to order more powder shake...he said it would take 5 to 6 days to get here. We need to let [client #2238's dad] know when [client #2238] gets down to 6 cans..." During interview on 2/5/21 client #2238 reported: - he was on the 600 hallway - He received protein shakes - He missed yesterday (2/4/21) and today (2/5/21) protein shakes - His parents brought the protein shakes to the facility - the nurse told his parents he was out of the protein shake - He doesn't know when he would get the shake - He needed the protein shakes because he could not have meat During interview on 2/11/21 client #2238's father reported: - "it was a constant battle with the facility" - client #2238 did not receive his protein shakes - this was not a regular protein shake - the shake was needed for medical reasons - client #2238 had a rare disease called PKU - his system could not breakdown proteins - he's contacted the CNO and "showed my butt" - he called the nurses on a continuous basis and received no return calls - he called the CNO on 2 occasions (no time frame given) and he didn't return his calls	V 314		

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V 314	Continued From page 20 - one Saturday (no time frame given) he called for 1 ½ hours and no one answered the phone - He called at least 11 times that Saturday - if he doesn't get the protein shake, he could have mood swings - 85% of the protein shake was his diet ...due to limited protein - client #2238 also had a dietician (outside of SBC-G) - the older and bigger he got, the protein shake amount increased - "he would not fall out and die," if he didn't get the protein shakes, however, it could cause cognitive & behavioral issues - he was told client #2238 had behaviors (cursing, being disrespectful) - client #2238 recently called him and he (dad) asked to speak with a nurse - The nurse said he had 3 cans left - client #2238 ran out of his protein shake recently - he requested nurses to call when it was down to 6 cans - it took a week for the protein shakes to arrive at his home - client #2238 went 5 days without the shake - without the shake he could become malnourished since it made up 85% of his nutrition During interview on 3/5/21 House Supervisor (HS)/Registered Nurse (RN) #4 reported: - she was not assigned to any unit - been at SBC-G for 7 years - she worked 7am - 7pm - any discrepancies on the MARs should be brought to the HS's attention by the nurses - an initial circled on the MAR would prompt a person to look at the back of the MAR for the reason it was circled	V 314		

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V 314	Continued From page 21 - dad brought the protein shakes to the facility - if the protein shake was not available, it should be written on the MAR that supply not available at this time - if the protein shake was running low, dad needed to be contacted - staff should not wait until shake was low to contact client #2238's dad - may cause client #2238 to miss his protein shake - they needed to give dad time to order and bring the protein shake to the facility During interview on 3/8/21 Licensed Practical Nurse (LPN) #2 reported: - she had worked at the facility since July 2020 - worked 7am - 7:30pm and then some - had worked 500-600 hall since January 2021 - she passed medications, daily charting, contacted family with updates - she was familiar with client #2238 and his protein shakes - he received the protein shakes at 8am & 2pm - there was a time the protein shakes were out - this was before she was client #2238's nurse - there were plenty of the protein shakes at the facility now - was not sure when dad needed to be contacted when the protein shake was low - if a medication was not available or client refused...the nurse circled their initials on the MAR - reasons the initials were circled should be documented on the back of the MAR During interview on 3/10/21 HS/RN #4 reported: - LPN#2 informed her client #2238 missed his protein shake in February 2021 - LPN#2 initials were circled and documented 2/5/21 - 2/9/21 for client #2238	V 314		

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V 314	Continued From page 22 - there was only one documentation written on the back that stated it was not available - each day and time the protein shake was out, reasons needed to be documented on the back of the MAR - this error should have been caught during the nurses 24 hour nightly checks - if this medication error was brought to her attention, this would be an issue for her - the nurse would receive a coaching and a corrective action During interview on 2/11/21 client #2238's Managed Care Organization (MCO) care coordinator reported: - she had worked with client #2238 since September 20, 2020 - has not met him personally due to COVID (Coronavirus disease) - she spoke with him by phone during the monthly CFT (child & family team) meetings - dad shared some barriers in regards to SBC-G - client #2238 has PKU and was not receiving his protein shakes - this was an ongoing issue prior to her involvement with client#2238 - dad was upset because of the communication with the facility's staff - dad agreed to bring the protein shakes to the facility - staff at the facility had to let him know prior to the shake getting low - dad had it marked on a calendar when the protein shakes should run out - he knew when staff should contact him - she's had a hard time contacting staff at the facility - she had to get her supervisor involved to reach staff at the facility	V 314		

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V 314	Continued From page 23 - it would be weeks before someone would respond - during a CFT 11/22/20, the (interim) CNO was too busy to join - client #2238's therapist was not aware of the protein shake issue and asked the interim CNO to join - the interim CNO said he would contact dad but he never called - She emailed the interim CNO in November 2020 about the CFT - he didn't respond During interview on 2/18/21 a former RN reported: - she started work at the facility in September 2020 - she worked 7pm - 7am - her last day at the facility was 2/10/21 - there was a client with PKU - the last day she worked, client #2238 was out of his protein shake - he had been out for 3 days or probably longer - it was dayshift nurses responsibility to notify client #2238's dad when the protein shake was low - without the protein shake, it caused aggression, depression and emotional outburst - she called dad and explained client #2238 was out of the protein shake for 3 days - dad was not aware he was out of the protein shake - it took 6 days for the shake to be ordered - dad was very upset he was not contacted During interview on 3/3/21 & 3/5/21 client #2238's Metabolic dietician from the physician's office reported: - she had not seen client #2238 in awhile - she heard he was committed in a facility	V 314		

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V 314	Continued From page 24 - they liked to see their patients every 6 - 12 months - he was last seen in 2019 - a physician at the hospital where she was employed wrote the script for the protein shakes - usually the physician liked a yearly checkup prior to written scripts - due to the (COVID) circumstances, the physician continued to write scripts - the formula helped give client #2238 protein - the PHE in the protein shakes helped break down protein - if PHE levels built up it in the brain, it could cause: brain damage; loss of focus; memory problems; mood disorder and behavioral issues - behavioral issues like: aggression, but it depended on the client...everybody reacted different - it would take months and years without the protein shake to cause any damage - client #2238 had been seen by their facility since birth - he weighed 87 pounds at his last visit - protein shakes needed to be adjusted, based on his age and weight - last Sept 2020 dad called and requested their hospital physician to contact SBC-G's physician - dad was concerned about client #2238 protein shakes not being administered - a physician from their hospital contacted SBC-G and spoke with the facility's physician - their facility has not heard anything back from SBC-G - SBC-G felt they could handle client #2238's PKU - a teenagers appetite increased - his diet may need to be adjusted - if client #2238 was 145lb ...this was a healthy weight but the PHE levels may not be accurate - he received 180grams at 87lb (2019)	V 314		

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V 314	Continued From page 25 ...should be getting at least 330grams During interview on 3/10/21 SBC-G's dietician reported: - she had worked with SBC-G since May 2016 - she visited SBC-G two - three times a week - completed consults; dealt with eating disorders; weight loss - she was familiar with client #2238 - she completed an initial assessment for him yesterday - she completed assessments quarterly - client #2238 could not process amino acids and the formula provided the needed protein - he's gained 47lbs since he's been at SBC-G - he's also had a growth spurt, which is good - she's not part of the decision for the protein shake adjustments - the decision would be made by the nurses and the physicians - she has not worked with any outside agencies in regards to client #2238's PKU - SBC-G was capable of meeting client #2238's dietary needs - There were no requirements SBC-G had to work with outside agencies - His diet was not hard to maintain - It does not require special products - If he missed a few days of his protein shake, it would be no immediate affects During interview on 3/18/21 the facility's Nurse Practitioner (NP) reported: - she worked with the facility for 3 years - she evaluated new patients, assessments of any acute/chronic issues, - was familiar with client #2238 indirectly - the dietician talked with her in passing about his diet - he was on an appetite stimulant since	V 314		

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V 314	Continued From page 26 admitted - he was so "puny" when he was admitted - she discontinued the medication this week - she wanted to see if he could gain weight without the stimulant - the facility's psychiatric physician followed him closer than she did - there were random meetings with the dietician, nothing scheduled - PRTF clients could see outside physicians even if they were admitted to SBC-G - she completed the referrals - she's only aware of a psychiatric hospital that treated him prior to being admitted to SBC-G - (was not the hospital that treated his PKU) During interview on 3/19/21 the facility's psychiatrist reported: - worked at SBC-G for 8 years...5 years on the PRTF side - a contracted medical team dealt with the medical side for client #2238 - the NP was sent from the contracted agency to SBC-G - he visited the clients once a week - client #2238 had an inborn error of metabolism - he was followed by an outside entity physician - he reached out to that physician last summer to see if he needed to be doing anything different - the outside physician requested to be contacted if any major changes in behavior or presentation - he didn't know if she (outside physician) still saw client #2238 - he was not involved with the protein shakes but knew about it - client #2238 worked with SBC-G dietician - He does not work directly with the dietician	V 314		

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V 314	Continued From page 27 During interview on 3/22/21 the Assessment & Referral Specialist at SBC-G reported: - he was the previous interim CNO for 9 months - the new CNO took the role a month ago (February 2021) - only time he was involved with client #2238 was when dad was upset he didn't receive his amino acid shakes - he had several office meetings with dad - dad seemed ok after the meetings - he decided to keep all the protein shakes in his office - he knew 1 can lasted 2 days and the nurses should used 3 - 4 cans a week - he was not sure how dad became the person to bring the protein shakes to SBC-G - he became the Interim CNO beginning of July 2020 - he was not aware of any time the protein shakes ran out - he does not recall being requested to join any CFT's for client #2238 - there were no time frames to return calls - he tried to return calls within 24 hours or as soon as he could - any concerns or issues with him not responding to guardian or parents have not been brought to his attention During interview on 3/23/21 the CNO reported: - she started at SBC-G on 2/1/21 - she was responsible for nursing 24/7 - the House Supervisor reported to her - lots of opportunity to put more structure and accountability for services provided - she was aware of client #2238's PKU diagnosis - when she started, his shakes were available	V 314		

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V 314	Continued From page 28 because there were a couple of cases in her office - she asked why and was told to monitor the number of shakes being used - the protein shakes are still located in her office - the House Supervisor would get the shakes when needed as their tracking system - the tracking system notified the House Supervisor when dad needed to be contacted for more protein shakes During interview on 3/23/21 the Director of Quality Compliance and Risk Management reported: - she didn't know anything about client #2238's PKU until notified by the MCO - she spoke with the interim CNO - he kept the cases (protein shake) in his office - she submitted her findings to the MCO - she had not heard anything back from the MCO, so she thought it was resolved - their agency worked with outside medical providers in regards to client care - it was completely up to SBC-G medical providers, the families and the outside medical providers to work together B. Review on 3/18/21 of the metabolic dietician office visit dated 9/20/19 for client #2238 revealed: - laboratory tests: weekly blood samples for PHE levels recommended: Goal PHE level 120-360 Review on 3/17/21 & 3/23/21 of client #2238 labs at SBC-G revealed: - general labs were completed 6/1/20; 10/5/20; 12/7/20 and 2/6/21 - no documentation PHE labs were done	V 314		

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V 314	Continued From page 29 During interview on 3/18/21 the facility's NP reported: - protein levels are looked at closely by the NP and SBC-G dietician - client #2238's protein levels were checked February 2021; December 2020 & October 2020 - the general panel of labs didn't include the PHE levels - the PHE was a more specific lab that had to be ordered - she does not recall this lab being ordered - during a later call back, there were no orders for PHE levels, therefore it had not been checked - general labs were completed on all clients every 6-8 weeks - no special test was done for client #2238's PKU During interview on 3/19/21 the facility's psychiatric physician reported: - he evaluated the clients since they were on psychiatric medications - they required labs due to medications like Risperdal - he followed blood sugars ...observed cholesterol levels - he monitored blood levels once every 6 months - client #2238's protein levels were monitored by an outside entity - if he ordered special labs for client #2238 PKU ...he wouldn't know what to do with the results - PKU was not his expertise - he was a psychiatrist During interview on 3/22/21 the Assessment & Referral Specialist at SBC-G reported: - he didn't order any PHE labs while he was interim CNO ...that was the medical team	V 314		

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V 314	Continued From page 30 During interview on 3/22/21 client #2238's Metabolic dietician with the physician's office reported: - PHE levels monitored the amino acids client #2238 couldn't breakdown - it was monitored by pricking the finger - client #2238's dad monitored it weekly at home and sent bloodwork to State lab - it could also be done by drawing plasma amino acid...arm stick with a needle - these were specific labs that had to be requested - PHE levels could not be monitored through routine lab work - general lab work was not helpful for PKU clients - the PHE levels for teenagers should be monitored every 2-4 weeks depending on the patient - it depended on the patient's growth spurts or if they notice something was off, etc. C. Review on 3/23/21 of client #7624's record revealed: - 17 years old - he was admitted 9/1/20 - Diagnoses: Post Traumatic Stress Disorder, Bipolar Disorder unspecified history, Disruptive Behavior Disorder, ADHD by history and ODD by history - a physician's order dated: 9/4/20 Boost three times (8am, 2pm & 8pm) a day with meals (to increase calories and protein) - a physician's order dated 2/17/21: Boost four times a day with 2 at bedtime (8am, 2pm & 8pm) Review on 3/23/21 of the January 2021, February 2021 & March 2021 MARs for client #5101 revealed:	V 314		

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V 314	Continued From page 31 - 1/8/21 blank spaces at 8am, 2pm and 8pm staff initial circled - 1/9/21 staff initials circled at 8am, 2pm and 8pm - 1/10/21staff initials circled at 8am, 2pm and 8pm - 1/20/21 staff initialed circled at 8pm - 1/21/21 staff initials circled at 8am and 8pm...blank space at 2pm - 1/22/21 - 1/25/21 staff initial circled at 8am and 2pm - 1/26/21 - staff initial circled at 8pm - 1/27/21 staff initial circled at 8am and 2pm - 1/28/21 circled at 8pm - 1/31/21 blank at 2pm and circled at 8pm - 2/11/21 blank spaces at 8am & 2pm - 2/12/21 - 2/14/21 blank spaces - 2/15/21 staff initial circled at 8am and 2pm - 2/17/21 initial circled at 8am - 3/10/21 - 3/11/21 blank spaces at 8am and 2pm - No documentation of why staff initials were circled During interview on 3/19/21 HS/RN #4 reported: - if blank spaces are on the MAR, she doesn't know what it meant - there should not be blank spaces on the MAR 2. The following is an example of how the facility failed to coordinate to ensure consents were obtained prior to medication administration: Review on 3/23/21 and 3/24/21 of client #5101's record revealed: - 12 years old - admitted on 6/16/20 and discharged 2/19/21 - diagnoses of ODD & ADHD A. Review on 3/23/21 of CFT meetings for client	V 314		

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V 314	Continued From page 32 #5101 revealed: - CFT 10/4/20: "...client #5101 doesn't know how many PRN (as needed) medications he has taken over the past month. His mom then explained that she has been called four times over the past two weeks due to [client #5101] unsafe behaviors...[client #5101's] mom confirmed that the MD still has not called, which is something that she would like to see happened..." - CFT 11/12/20: "...the therapist noted that [client #5101] is often asleep during group therapy and misses class frequently. The therapist expressed concerns for [client #5101] frequent PRN use and how that has been preventing him from fully participating in his treatment. The therapist shared that she has often observed [client #5101] requesting a PRN rather than attempting to deal with the problem. [Client #5101] parents also expressed concerns for [client #5101] frequent PRN use. [Parent] shared that he was especially concerned given the family history of substance use and addiction on both sides of the family..." Review on 3/24/21 of client #5101 consents revealed: - parental consent signed on 6/17/20 for the following by mouth (PO) medications: Zyprexa, Vistaril, Thorazine and Trazodone - parental consent signed on 6/17/21 to contact the parent first prior to the following intramuscular (IM) injections: Ativan, Benadryl and Thorazine - no documentation to revoke medication consents by the parents - call mom before giving was written on the November MAR beside the medications Vistrial and Zyprexa - no documentation of written or verbal consents for behavioral medications administered	V 314		

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V 314	Continued From page 33 from November 2020 - February 2021 Review on 3/24/20 of client #5101's October and November 2020 MAR revealed the following: - 10/8/20 (1:50pm) Zyprexa 10mg (milligrams) agitation (effective) - 10/8/20 (1:50pm) Vistaril 50mg anxiety (slightly effective) - 10/8/20 (4:50pm) 10/8/20 Thorazine 50mg increased agitation (effective) - 10/9/20 (9:25pm) Zyprexa 10mg PO increased agitation (effective) - 10/9/20 (9:25pm) Vistaril 50mg for anxiety (effective) - 10/12/20 (2:45pm) Zyprexa 50mg PO anxiety (slight effect) - 10/14/20 (8:40pm) Trazadone 25mg insomnia (effective) - 10/23/20 (7:58pm) Trazadone 25mg insomnia (effective) - 10/23/20 (9:04am): Vistaril 50mg increased anxiety (effective) - 10/26/20 (8pm) Vistaril 50mg anxiety (not effective) - 11/3/20 (Trazodone 25mg) (7:31pm); 11/7/21 (7:50pm); 11/12/20, 7:58pm and 11/16/20 at 8:05pm - 11/3/20 (Vistaril 50mg (milligrams) for agitation... given on 11/3/20 at 10:11am and 11/5/20 at 8:30pm - 11/3/21 (Zyprexa 10mg) for agitation was given on 11/3/20 at 10:11am & 11/4/20 at 8:30pm - 11/11/20 (8pm) evening meds not given asleep ...3:10pm Thorazine 50mg - 11/12/20-(11:00am) Zyprexa IM injection: - 11/17/20 (8:56pm) Thorazine 50mg) IM & Benadryl 50mg IM - 11/17/20 (9:30pm) Lorazepam 1mg IM - 11/23/20 Thorazine 50mg IM & Benadryl 50mg IM given	V 314		

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V 314	Continued From page 34 - 2/7/21 - (9:00am) Vistaril 50mg for anxiety (effective) - 2/10/21 -(8:00pm) Vistaril 50mg forincreased anxiety During interview on 3/16/21 client #5101's mom reported: - She was familiar with the parentalconsent forms - She would not have signed them if sheknew she wouldn't be contacted prior to injections - She was told at admissions it was the last resort - client #5101 received behavioralmedications without her consent - if it was Tylenol she was Ok ...something over the counter - she made it clear to the interim CNOshe wanted to be contacted - he said he would call first, the injection was the last resort - she was notified after the shot was given or sometimes not contacted - she found out during CFT meetings he received the behavioral shots more than 1time - during a November CFT, a prior therapist didn't know client #5101 had receivedZyprexa and Vistrial - client #5101 would tell the nurse hefelt anxious and would be given a PRN - he became dependent upon thePRN medications - the MCO said she (mom) could revoke the consents - she requested the medication consents be revoked after 2 occasions the behavioral medication was being given without her consent - two nurses she was not familiar with acted as if it was OK to give the behavioral PRNs - she called the interim CNO to let him know	V 314		

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V 314	Continued From page 35 the PRN medications were still administered - "he made a bunch of excuses" ...he said it would not happen again - it happened again and the interim CNO never called her back after leaving several messages - she recalled it was in mid October 2020 when she requested consents be revoked - the prior therapist noticed a pattern of the PRN medications being given - nurses would call and said your child was out of control and agitated - she would speak to him and he would say a nurse made him mad or he got frustrated in class - he would walk out to calm down and was restrained - she requested if Thorazine or any behavioral medications be given...she be notified - she did not want him drugged the whole time and not receive treatment - their first resort was the injection - she thought Benadryl was for a rash or allergic reaction ...she didn't know it could be given with Thorazine During interview on 3/16/21 the Assessment and Referral Specialist reported: - if parents signed consent forms at admission for a IM or PO ...they are notified after the restraint - if a parent noted on the consent form they wanted to be contacted prior to medication given ...staff will try to call parent ...if client was a threat to self or others, may not be able to accommodate the parents wishes - if a parent rescinded a consent...means those consents were removed from the chart - parents needed to be contacted, if consents are rescinded - he was not aware of an IM given without escalation first	V 314		

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V 314	Continued From page 36 B. Review on 3/24/21 of client #5101's record revealed: - a physician's order dated 8/27/20: Metoprolol 50mg am...increased heart rate (treat high blood pressure...illnesses that can cause an irregular heartbeat) - August 2020 MAR "need consent" was documented - a written document of Metoprolol witnessed by 2 nurses on 9/2/20 - no reasons documented between the following dates 8/27/20 -9/1/20 - MARs revealed Metoprolol was administered from September 2020 until discharge (February 2021) During interview on 3/16/21 client #5101's mom reported: - at discharge she was made aware client #5101 was on a heart medication due to increase heart rate - she was not made aware her son had problems with his heart or why he was put on Metoprolol - she was given a script and told not to give the medication if heart rate under 60 - she and the MCO tried to figure out when he was put on the medication - her husband has tried several times to reach someone in medical records at SBC-G - his pediatrician didn't know why he was put on the medication - they needed his medical records - pediatrician wanted to know if client #5101 needed to see a cardiologist - her husband called SBC-G the beginning of March after client #5101's appointment the end of February 2020 - he left another voicemail last week and no	V 314		

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	20140058	A. BUILDING: _____ B. WING _____	C 03/26/2021

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V 314	Continued From page 37 return call During interview on 3/18/21 client #5101's Complex Care Coordinator reported: - he worked with clients that were in PRTF settings for more than 6 months - had worked with client #5101 for the last 3 weeks (3/1/21) - mom said client #5101 was put on heart medication (Metoprolol) while at SBC-G - the heart medication was not in any of his discharge information - he planned to inquire about the heart medication from SBC-G - mom has tried to obtain medical records from SBC-G - He needed to be informed about the heart medication because he kept a list of all medications clients were on - this helped with interaction purposes and to be able to coordinate with medical professionals During interview on 3/18/21 the NP reported: - client #5101 was probably put on the medication due to increased heart rate or anxiety - she did not have his medical information in front of her - should be documented in the nurses chart along with the consent form During interview on 3/18/21 Medical Records Specialist #1 reported: - a medical records request for client #5101 was not received - she was out of the office Friday 3/12/21 & Monday 3/15/21 and have to play catch up - she had not checked her voicemail this week - she also dealt with court issues - she was told that court was her first priority - if she received a consent ... it was usually	V 314		

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V 314	Continued From page 38 followed up on by end of that week - another representative worked in medical records but she was PRN - the PRN representative (rep) had a folder on her desk that she could check to see when request came in - if the PRN rep was out of the office ...her voicemails were forwarded to her ...since she was the full time rep 3. The following are examples of how the facility failed to coordinate to ensure parents and agencies received school records in a timely manner A. Review on 2/1/21 of client #7347's record revealed: - 17 years old - admitted 9/17/20 - diagnoses of Schizophrenia and PTSD by history During interview on 3/9/21 client #7347's mom reported: - he was discharged January 2021 - it was difficult to get his grades after discharge - he could not get back in regular school without his grades - she had to involve the MCO to get his grades - the MCO said she was supposed to receive grades after his discharge - he missed a week of school During interview on 3/9/21 client #7347's MCO care coordinator reported: - had some issues with school records after discharge for client #7347 - mom contacted her and said SBC-G had not sent school records to get him enrolled	V 314		

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V 314	Continued From page 39 - she (MCO) contacted the therapist and she refused to give school information - the therapist transferred her to medical records - she had a difficult time communicating with SBC-G - she had a hard time reaching client#7347 when he was admitted - they do not answer the phones - one time she held the phone for 30 minutes - communication was difficult with staff and management ...difficult time reaching clients assigned to her - the parents have the same complaint B. Review on 2/1/21 of client #7680's record revealed: - 17 years old - admitted 9/4/20 - per guardian discharged 2/24/21 - diagnoses of ODD; Disruptive Mood Dysregulation and Generalized Anxiety Disorder During interview on 3/9/21 client #7680's guardian (Department of Social Services) reported: - discharged February 24, 2020 - difficulty getting grades - she emailed teacher at SBC-G and received no response - they did send his classes taken at SBC-G and the grades but not the transcript - the transcript was the hold up - she needed to know if he earned any credits at SBC-G - never got the transcript - they allowed him to attend school based on other transcripts from other schools During interview on 3/9/21 the medical records	V 314		

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V 314	Continued From page 40 specialist #3 reported: - she located an email from the therapist for client #7680 grades - the therapist requested grades on 2/17/21 prior to his discharge - She took the therapist the grades - the transcript was not requested During interview on 3/23/21 the Quality Compliance and Risk Management reported: - after the 11/25/20 survey, they revised the Case Management/Discharge Planning policy - the prior Director of Clinical services reeducated the therapists of the process of sending over requests to medical records when requested by a family - she spoke with medical records staff, in regards to requests being done in a timely manner - according to policy, there were no specific time frame when the medical records needed to be processed - however, medical records were told within 30 days unless specified in a letter another time frame - family members requesting information ...turnaround period was within 30 days - it should be explained in the discharge meeting the process of obtaining medical & educational records - she rarely received calls in the 3 years she has been at SBC-G in regards to parents/guardians, outside entities not receiving records (school/medical) in a timely manner - maybe 5 calls in 3 years - she was not sure if management contact information was given at admission or during discharge - it would be beneficial to have a checklist ...for	V 314		

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V 314	Continued From page 41 obtain all belongings; all documents signed... - she has not received any phone call from families complaining about lack of communication - families will complain to MCO - her expectation was for staff to respond to their voice message within 24 - 48 hours (more toward 24 hours) - this has been expressed to staff - someone shouldn't have to keep calling to reach a staff - therapist have communication forms to fill out and document calls ...should be in client's record Review on 03/26/21 of the facility's Plan of Protection (POP) dated 03/26/21 submitted by the Director of Compliance/Risk Management revealed the following: "What immediate action will the facility take to ensure the safety of the consumers in your care? 1. Immediately to ensure the safety of the current patients in our care. All medical records will be reviewed to ensure the coordination of care for all patients to include but not limited to, medication issues, medical issues, consents, and coordination with other individuals and agencies. Any identified issues will be immediately resolved. 2. Documented morning rounds to be implemented with the Clinical team by 4/5/2021, to evaluate coordination of care regarding any updates or changes in patient condition and follow up to ensure any family notifications are made, as well as updating the plan of care as indicated. 3. Current policies are being reviewed, revised and or created to ensure compliance with 10A NCAC 27G. 1901(f). Staff will be educated on all policy and procedural changes. 4. Re-implementation of the discharge checklist to ensure all coordination of services has occurred. The Admissions checklist will also	V 314		

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V 314	Continued From page 42 be re-implemented to include but not limited to patient orientation, receipt of updated patient handbook to include the process for requesting Medical/School Records." "Describe your plans to make sure the above happens. 1. Clinical and Nursing services will audit all current PRTF patient charts to ensure coordination of services are occurring as per 10A NCAC 27G. 1901(f). 2. Morning rounds from the Clinical Team will be reported out in morning meeting the following day with any identified issues and or resolutions. The House Supervisor (HS) will complete weekend rounds and report out to the Administrator on Call (AIC)." "Strategic Behavioral Center-Garner will be in compliance with the actions on this POP by 4/26/21." Review on 3/26/21 of the facility's revised POP dated 3/26/21 submitted by the Director of Compliance/Risk Management revealed the following: "What immediate action will the facility take to ensure the safety of the consumers in your care? 1. On 3/26/2021, to ensure the safety of the current patients in our care all medical records will be reviewed by the Director of Clinical Services (DCS), and Chief Nursing Officer (CNO) to ensure the coordination of care for all patients to include but not limited to, address medication issues including validation of appropriate consents; ensuring residents with medical issues have updated treatment plans to reflect care provided including diagnostic or laboratory studies as needed. Ensuring that all services provided are accurately documented in the medical record.	V 314		

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V 314	Continued From page 43 2. Documented morning rounds to be implemented with the CNO or designee and the DCS or designee by 3/29/2021, to evaluate coordination of care regarding any updates or changes in patient condition and follow up to ensure any family notifications are made, as well as updating the plan of care as indicated, as evidence by ensuring patients with medical problems has plans to address those issues. Each nurse and therapist will have to give a brief report of their residents to include the above information with. The DCS and CNO will validate via medical record review that identified issues has been updated. This information will be reported out daily in morning meeting with the Leadership team. 3. Current policies pertaining to coordination of care to include but not limited to request for information, patient and family education, and treatment team processes are being reviewed, revised and or created to ensure compliance with 10A NCAC 27G.1901(f). Staff will be educated on all policy and procedural changes. 4. By 4/5/2021, re-implementation of the discharge checklist to ensure all coordination of services has occurred. The Admissions checklist will also be re-implemented to include but not limited to patient orientation, receipt of updated patient handbook to include the process for requesting Medical/School Records including the timeframe (no more than 30 days) for receiving requested information unless otherwise indicated in the correspondence; a welcome letter to include names, and contact information for team members. This will also include expectations regarding timeliness in communication with families (i.e., calls to be returned within 48 hours)."	V 314		

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V 314	Continued From page 44 "Describe your plans to make sure the above happens. 1. Clinical and Nursing services will audit all current PRTF patient charts to ensure coordination of services are occurring as per 10A NCAC 27G.1901(f). The finding will be charted and reviewed in morning meetings starting 3/29/2021. 2. Morning rounds will begin 3/29/2021 by the CNO and DCS or designees and results will be reported out in morning leadership meetings on the following day with any identified issues and or resolutions. The House Supervisor (HS) will complete weekend rounds and report out to the Administrator on Call (AOC)." "Strategic Behavioral Center-Garner will be in compliance with the actions on this POP by 4/26/2021." This deficiency constitutes a re-cited deficiency. Client #2238 was 15 years old and admitted to the facility on 5/29/20. He was diagnosed with PKU at birth. This was a rare disease that made it difficult for the body to break down proteins . He was ordered to drink Phenex (PHE) (a protein shake) twice a day. The PHE in the protein shakes helped with the process of breaking down the proteins. In February 2021 he missed a week of the protein shakes due to the facility not coordinating with dad who was responsible for getting the shakes to the facility. Client #2238 metabolic dietician since birth, said missed shakes would take months and years to cause any damage. However, the PHE levels needed to be monitored every 2-4 weeks. Build up of the PHE could cause brain damage, loss of focus, memory problems, mood disorder and behavioral issues. Client #2238's PHE levels had not been checked since his admission to the facility. The	V 314		

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V 314	Continued From page 45 NP said the psychiatric physician at SBC-G followed client #2238 closer than she did. SBC-G's physician said he was the facility's psychiatric physician. His expertise was not PKU. There were several treatment plan updates to address client #2238's behaviors of verbal & physical aggression, irritability, punching and kicking walls. There was a letter sent to SBC-G from the metabolic dietician's office attempting to coordinate services but SBC-G medical team did not respond. SBC-G's dietician felt they were capable of meeting client #2238's PKU needs. Client #5101 was placed on Metoprolol for increased heart rate in August 2020. His parents were not aware of the medication until he was discharged in February 2021. Client #5101 was given several behavioral medications by mouth and intramuscular without the consent of the parents. Client #7624 had a physician's order for Boost three times a day to increase his calories and protein. He missed his Boost shake 15 days from January 2021 - March 2021 with no documented reasons why. Client #7347 and #7680 missed a week of school after discharge from the facility due to requested grades not being received from the facility. Due to the systemic issues at the facility, this deficiency constitutes a Continued 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		

STRATEGIC
BEHAVIORAL CENTER

April 23, 2021

NCDHHS/DHSR
Rhonda Smith, Facility Compliance Consultant 1
Tinika Ferguson, MSW, Facility Compliance Consultant 1
1800 Umstead Drive
Williams Building
Raleigh, NC 27603

RE: Follow Up and Complaint Survey completed March 26, 2021. Intake #NC00172482, #NC00171457, #NC00173236, #NC00173666, #NC00173216, #NC00172738, #NC00172105, #NC00173116, #NC00173339, #NC00174828.

Dear Ms. Rhonda Smith & Tinika Ferguson:

Enclosed is the A2 and Standard Level of Deficiencies Plan of Correction for Strategic Behavioral Center-Garner.

Respectfully,

Evelyn Alsup, CEO

Evelyn Alsup

Enc: Plan of Corrections

qsj

3200 Waterfield Drive ◆ Garner, North Carolina 27529
P (919) 800-4400 ◆ F (919) 573-4163