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	MHH0976	A. BUILDING: _____ B. WING _____	05/10/2021

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CAROLINA DUNES BEHAVIORAL CENTER	2050 MERCANTILE DRIVE LELAND, NC 28451

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V 000	INITIAL COMMENTS An annual, complaint and follow-up survey was completed on May 10, 2021. The complaint was substantiated (intake #NC00176202). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment Facility for Children and Adolescents.	V 000	Carolina Dunes Behavioral Health takes these findings seriously and has implemented what we feel is an effective plan of action to address the identified deficiencies and monitor for compliance with actions taken. Pursuant to your request, the response is structured as follows: 1) the measures put in place to correct the deficient practice, 2) the measures put in place to prevent the problem from occurring again, 3) the person who will monitor the situation to ensure it will not occur again, and 4) how often the monitoring will take place. Additionally, all education provided throughout this plan of correction has also been added to the new hire orientation, with the next class starting on June 7, 2021.	
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and	V 105	V 105 All of the previous day's Incident Reports on all units, to include reports of restrictive procedures, are being summarized and faxed to DRNC on a daily basis by the Risk Management Coordinator (Friday through Sunday reports will be sent on Mondays). Fax confirmations are being saved as evidence of transmission and verified daily by the Director of Quality & Risk Management (the vacant position that contributed to the deficiency has been filled as of May 3, 2021). The Director of Quality & Risk Management is verifying daily that all of the previous day's incident report summaries have been faxed to DRNC. This daily verification is being reported daily to the CEO in the Safety meeting and documented in the meeting minutes (Friday through Sunday reports will be made on Mondays).	6-7-21

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V 105	Continued From page 1 recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105	The Director of Quality & Risk Management is responsible for monitoring this process and reporting it daily to the CEO (Friday through Sunday reports will be made on Mondays). The Director of Quality & Risk Management is tracking the daily faxing of the previous day's incident report summaries to DRNC (Friday through Sunday reports will be sent on Mondays) and reporting this daily in the Safety meeting to the CEO and monthly in the Quality Council committee meeting.	

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V 105	Continued From page 2 This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to implement written standards that assured operational and programmatic performance meeting applicable standards of practice to report serious occurrences to the State designated Protection and Advocacy system. The findings are: Review on 5/03/21 of the LME-MCO (Local Management Entity-Managed Care Organization) communication Bulletin J287, "Clarifying the Reporting Standards for Psychiatric Residential Treatment Facilities (PRTF)" dated 5/11/18 revealed: -" ...Serious Occurrences are any event that result in Restraint or Seclusion, Resident's Death, Any Serious Injury to a Resident, and a Resident's Suicide Attempt. NC § 483.374 specifies that facilities must report each Serious Occurrence to both the State Medicaid agency (Division of Medical Assistance - DMA) and, unless prohibited by State law, the State-designated Protection and Advocacy system (Disability Rights North Carolina - DRNC)." -"DRNC reports are to be faxed to (919) 856-2244." Review on 5/03/21 - 5/10/21 of facility restrictive intervention records from 3/06/21 - 5/03/21 revealed no serious occurrences involving seclusion or restraint had been reported to DRNC as required for the following clients: - Client #1 - Restraints on 4/27/21, 3/29/21, 3/26/21, 3/24/21, 3/18/21, 3/17/21, 3/09/21 - Client #2 - Restraints on 4/04/21, 3/31/21, 3/23/21 - Client #3- Restraint on 4/29/21	V 105		

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V 105	Continued From page 3 - Client #4- Restraints on 4/20/21, 4/10/21, 3/31/21, 3/25/21, 3/22/21, 3/15/21 - Client #5 - Restraints on 3/28/21, 3/18/21, 3/8/21. - Former client #6 - Restraints on 4/22/21, 4/21/21, 4/16/21, 4/1/21 (4 times), 3/31/21, 3/29/21, 3/24/21, 3/22/21. Interview on 5/03/21 Quality Risk Coordinator stated: - Incidents were filled out using a WORD document and then faxed to DRNC. - He had contacted DRNC for clarification on required reporting of incidents and was informed reporting restrictive interventions were nice to do but not required. - Incidents were tracked through a spreadsheet but had not been completed in the last 90 days. - Restrictive interventions had not been reported to DRNC since the Quality Risk Director resigned. This deficiency was cited 4 times on 2/13/19, 5/16/19, 4/14/20, and 10/7/20.	V 105		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies.	V 114	V 114 The requirement for disaster drills to be held quarterly and repeated on each shift has been added to the Emergency Preparedness policy & procedure. The policy has been reviewed and approved by the Quality Council and Governing Board. The Director of Plant Operations will be responsible for ensure that both fire and disaster drills are held at least quarterly and repeated on each shift. This has been incorporated into the job description as a	6-7-21

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V 114	Continued From page 4 (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to have fire and disaster drills held at least quarterly and repeated on each shift. The findings are: Review on 5/03/21 - 5/05/21 of facility records from 4/01/20 - 3/30/21 revealed: - 1st quarter (4/01/20 - 6/30/20): No disaster drills documented on 1st, 2nd, and 3rd shift. - 2nd quarter (7/01/20 - 9/30/20): No fire drills documented on the 1st shift. - 3rd quarter (10/1/20 - 12/31/20): No disaster drills documented on 1st, 2nd, and 3rd shift. - 4th quarter (1/01/21 - 3/30/21): No disaster drills documented on 1st, 2nd, and 3rd shift. Interview on 5/05/21 client #1 stated: - There was one fire drill which was an actual fire emergency. - There were no disaster drills. Interview on 5/05/21 client #2 stated: -There had been 2 fire drills since her admission. -They had not practiced for a hurricane but there had been an emergency and they had to sit in the hallway in the middle of the night. Interview on 5/05/21 staff #1 stated: - Fire drills were completed once a month. - She had not been involved in any disaster drills. Interview on 5/05/21 staff #2 stated: - There had been at least 3 fire drills since she	V 114	requirement for the new Director of Plant Operations. The Director of Plant Operations will maintain a calendar of planned fire and disaster drills which will be provided to the CEO and Director of Quality & Risk Management on a monthly basis to ensure that all planned drills are held as scheduled. Compliance will be reported monthly to Quality Council as a standing agenda item. The Director of Plant Operations is responsible for ensuring that both fire and disaster drills are held at least quarterly and repeated each shift. The Director of Quality & Compliance will ensure each month at Quality Council that the fire and disaster drills have been completed for the month and document this in the meeting minutes. In the event the drills have not been held prior to Quality Council meeting each month, the Director of Quality & Risk Management will report this to the CEO, who will schedule the drills prior to the end of the month and personally ensure they are completed. The Director of Quality & Compliance will ensure each month at Quality Council that the fire and disaster drills have been completed for the month and document this in the meeting minutes.	

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V 114	Continued From page 5 was hired. - She was not aware of any disaster drills. Interviews on 5/03/21 and 5/7/21 Quality Risk Coordinator stated: - There were 3 shifts for Mental Health Technicians (MHT). - 1st shift was 6:45am- 3:15pm. - 2nd shift was 2:45pm- 12:15am. - 3rd shift was 11:45pm- 7:15am. - There had been a disaster "table top" drill on 11/18/20; he would send the report for surveyor review. Review on 5/7/21 of the "table top" drill dated 11/18/20 revealed: -Title of the drill: "Non-influx of COVID-19 (Coronavirus disease 2019) Patients Update 11/18/20" -Drill Scenario: 1 person presented for admission to the Inpatient Hospital with an elevated temperature and history of exposure to COVID-19. -This "table top"exercise was not a disaster drill for the PRTF (Psychiatric Residential Treatment Facility).	V 114		
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.	V 118	V 118 The Director of Nursing is re-training 100% of the Nurses in eMAR documentation. All Nurses assigned to work the floor will sign an attestation regarding re-training received in the following areas: • Bar code scanning vs. manual entry – All Nurses are being trained to utilize bar code reader scanning of the patient bracelets and the medications and to provide a reason for a manual entry	6-7-21

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V 118	Continued From page 6 (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; (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 in interviews, record reviews, and observations the facility failed to administer medications as ordered by the physician and maintain an accurate MAR affecting 5 of 5 clients audited (#1, #2, #3, #4, #5) and 1 of 1 former client (FC #6). The findings are: Finding #1: Reviews between 5/3/21 and 5/5/21 of client #1's record revealed: -15 year old female. -Admission date 2/19/21.	V 118	whenever bar code scanning is not possible. • Nursing Status Board – All Nurses are being trained to view the eMAR electronic Nursing Status Board multiple times throughout each shift and at the end of the shift for warnings and prompts and to reconcile those appropriately prior to the end of each shift. • Overdue Medications – All Nurses are being trained to view the "Patients with Medications Overdue" screen in the eMAR at the beginning and end of each shift and to reconcile those appropriately. • Patient's Response to Medication – All Nurses are being trained to provide follow-up documentation regarding the effectiveness of PRN medication. The Nurses are being trained on the expectation of reconciling the "Patients Needing Response to Medication" report in the eMAR prior to the end of every shift. • Patients with Orders Due – All Nurses are being trained on accessing the "Patients with Orders Due" report in order to anticipate upcoming Physician orders prior to their administration time so that they can be given timely. • Medication Orders to be Verified – All nurses are being trained on the expectation of reconciling the "Medication Orders to be Verified" report in the eMAR prior to the eMAR authorizing administration of the medication as ordered by the Physician. • Omission Report – All Nurses are being trained to ensure that all medications that are administered are documented as such in the eMAR and that any medication that is not administered for any reason (eg.,	

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V 118	Continued From page 7 -Diagnoses included bipolar disorder. Reviews between 5/3/21 and 5/5/21 of client #1's medication orders and order dates revealed: -2/19/21: Benztropine 0.5 mg (milligrams) twice daily. (involuntary movements) -2/19/21: Trazadone 100 mg at bedtime for insomnia. -2/22/21: Lithium 450 mg twice daily for bipolar disorder. -2/23/21: Magnesium Gluconate 500 mg at bedtime for chronic constipation. -2/28/21: Docusate Sodium 100 mg twice daily for constipation. -4/27/21: Zyprexa 10mg twice daily for mood. Reviews between 5/3/21 and 5/5/21 of client #1's MARs from 3/6/21 through 5/3/21 revealed: -3/15/21 and 4/11/21, 8:00pm doses of Benztropine 0.5 mg were not documented as administered. -3/15/21, 8:00pm dose of Trazadone 100 mg was not documented as administered. -3/15/21, 8:00pm dose of Lithium 450 mg was not documented as administered. -3/15/21, 8:00pm dose of Magnesium Gluconate 500 mg was not documented as administered. -3/15/21, 8:00pm dose of Docusate Sodium 100 mg was not documented as administered. -4/28/21, 8:00pm dose of Zyprexa 10 mg was not documented as administered. Interview on 5/5/21 client #1 stated: -She had been with facility since 2/19/21. -Medications were taken as prescribed. -She refused her medications one time. Finding #2: Reviews between 5/3/21 and 5/5/21 of client #2's record revealed:	V 118	patient refused medication) is documented in the eMAR with a reason. Any Nurse not having received this training by the June 7, 2021 target date will not be eligible to work until this training is received. The Medical Director is providing education to the Medical Staff regarding these processes and the expectations of the Nursing staff. The Director of Nursing has implemented a new process where each Nurse checks the Nursing Status Board prior to the end of the shift to determine whether any medications were not documented as administered, which will prompt the Nurse to provide eMAR documentation regarding why the medication was not administered as scheduled. The Director of Nursing is training all Nursing in this process, as well as the new form for all Nurses to complete, sign, and submit daily attesting to having checked the Nursing Status Board in the eMAR and addressed any discrepancies in medication administration. The Director of Nursing has instructed the Night Shift Nurses responsible for performing the 24-hour chart checks to include in their audit a check of whether medications ordered were indeed entered into the eMAR. The Director of Nursing has also instructed the Night Shift Nurses responsible for performing the 24-hour chart checks to include in their audit a check of whether any missed doses of medication are evident in the eMAR for the previous 24-hour period. If any	

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V 118	Continued From page 8 -17 year old female. -Admission date 1/20/21. -Diagnoses included post traumatic stress disorder (PTSD) and oppositional defiant disorder Reviews between 5/3/21 and 5/5/21 of client #2's medication orders and order dates revealed: -1/21/21: Neurontin 100 mg three times a day for mood. Reviews between 5/3/21 and 5/5/21 of client #2's MARs from 3/6/21 through 5/3/21 revealed: -3/26/21, 4/25/21, and 5/02/21, 2:00pm doses of Neurontin 100 mg were not documented as administered. Interview on 5/5/21 client #2 stated: -She had been with facility for approximately 3 months. -Medications were taken as prescribed. -She had not missed any medication doses. Finding #3: Reviews between 5/3/21 and 5/5/21 of client #3's record revealed: -16 year old male. -Admission date 3/19/21. -Diagnoses included mood Dysregulation disorder -4/14/21 sent to the emergency room (ER) via EMS (emergency medical service) to rule out appendicitis. Reviews between 5/3/21 and 5/5/21 of client #3's medication orders and order dates revealed: -4/15/21, 9 packs of Miralax in 64 ounces of Gatorade this am, drink within 1 hour, -3/28/21, 2000 units of Vitamin D daily for vitamin deficiency. -3/24/21 benzoyl peroxide 10% topical acne wash	V 118	missed doses of medication are discovered in the audit, the Nurse responsible for conducting the audit will report these to the Director of Nursing. The Director of Nursing will establish whether a Medication Variance Report has been completed and initiate one if necessary, including making the appropriate notifications to the Physician or Pharmacist. The Director of Nursing and the Director of Pharmacy will be responsible for monitoring these processes. Nurses not meeting expectations will be addressed using the Hospital's progressive disciplinary process. The Director of Nursing will generate a Medication Omission Report daily from the eMAR and report any discrepancies to the CEO in the daily Safety meeting (Friday through Sunday reports will be made on Mondays). The Director of Nursing will track any discrepancies and report trends and corrective actions taken monthly in Quality Council and monthly in Medical Executive Committee meeting.	

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V 118	Continued From page 9 to face/back/chest daily in shower for acne. Review on 5/4/21, and 5/5/21 of client #3's MARs from 3/19/21 through 5/3/21 (11 am) revealed: -4/3/21, 4/6/21, and 4/7/21 benzoyl peroxide 10% topical acne wash, scheduled for 8am, was not documented as administered and no reason for omission documented. -No documentation the Miralax ordered on 4/15/21 had been administered and no reason for omission documented on the MAR. -2000 units of Vitamin D daily had not been transcribed on the MARs and had not been documented as administered. Observations on 5/5/21 at 4:40 pm revealed there was no Vitamin D 2000 units on hand for client #3. Interview on 5/5/21 client #3 stated: -He was taken via EMS to the ER because of abdominal pain. -He refused the medication ordered for him following the ER visit because he was hungry and wanted to eat. He understood he could not eat and take the medication. -He had been given "some sort of pill" in the ER and his problem had resolved. He could not recall what they gave him. -He had never missed a medication. -He had never run out of a medication. -He had never refused a medication. Finding #4: Reviews between 5/3/21 and 5/5/21 of client #4's record revealed: -15 year old male. -Admission date 3/9/21. . -Diagnoses included PTSD, anxiety, conduct disorder; attention deficit hyperactive disorder	V 118		

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V 118	Continued From page 10 (ADHD); borderline intellectual functioning Reviews between 5/3/21 and 5/5/21 of client #4's medication orders and order dates revealed: -3/9/21: Depakote DRT (delayed release tablet) 500 mg twice daily for mood. -3/9/21: Buspar 5 mg twice daily for anxiety. -3/9/21: Zyprexa 5 mg at bedtime for mood. -3:9/21: Vyvanse 30 mg daily for ADHD. -3/13/21: Depakote DRT 750 mg at bedtime daily for mood -3/22/21 at 6:10 pm, administer Thorazine 50 mg IM (intramuscular route) one time now and Benadryl 50 mg IM one time now for for severe aggression. -4/10/21 at 5:48 pm, administer Thorazine 75 mg and Benadryl 50 mg IM one time now for aggression. -4/20/21 at 8 am, administer Thorazine 75 mg and Benadryl 50 mg IM one time now for severe aggression/agitation. Reviews between 5/3/21 and 5/5/21 of client #4's MARs from 3/9/21 through 5/3/21 (11 am) revealed: -3/10/21, 8 pm dose of Depakote DRT 500 mg was not documented as administered. -3/22/21, 8 pm MAR entries for Buspar 5 mg, Depakote DRT 750 mg, and Zyprexa 5 mg read, "pt. (patient) asleep form IM injections given earlier. -3/10/21 and 3/21/21, 8 pm (bedtime) doses of Zyprexa 5 mg were not documented as administered. -4/6/21 8am dose of Vyvanse 30 mg was not documented as administered. -4/10/21, 4/11/21, and 4/13/21, 8am MAR entries for Vyvanse 30 mg read, "Not administered...Drug not available." -3/27/21, 8am dose of Depakote DRT 500 mg	V 118		

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V 118	Continued From page 11 was not documented as administered. -3/22/21, 6:10 pm one time orders for Thorazine 50 mg and Benadryl 50 mg were not documented as administered. -4/10/21, 5:48 pm one time orders for Thorazine 75 mg and Benadryl 50 mg were not documented as administered. -4/20/21, 8 am orders for Thorazine 75 mg and Benadryl 50 mg were not documented as administered. Interview on 5/5/21 client #4 stated: -The doctor had been changing his medication orders. -The medication order changes had helped him. -He never missed any of his medications. Finding #5 Review between 5/3/21 and 5/5/21 of client #5's record revealed: -15 year old female -Admission date 8/28/20 -Diagnoses of PSTD unspecified, oppositional defiant disorder moderate and Asthma. Review between 5/3/21 and 5/5/21 of client #5's medication orders and order dates revealed: -8/29/20: fluticasone nasal spray 1 spray twice daily for allergies. -8/29/20: montelukast 5 mg at bedtime for allergies. -11/20/20: aripiprazole 15 mg at bedtime for mood. -8/29/20: fluticasone-salmeterol 100 mcg-50mcg (microgram) powder, 1 puff twice daily for asthma. -1/17/21: lactase 3000 units 1 hour before each meal for lactose intolerance with dairy meals. -4/13/21: venlafaxine extended release 150mg at bedtime for Depression.	V 118		

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V 118	Continued From page 12 Review between 5/3/21 and 5/5/21 of client #5's MARs from 3/6/21 through 5/3/21 (11 am) revealed: -4/2/21, fluticasone 2nd dose was documented as not administered, not available. 4/11/21 was not documented as administered. 4/14/21 was documented on 4/15/21 not administered Patient refused. Documented as administered once on 4/19/21 and 3 times on 4/20/21. 4/23/21 was not administered Patient refused. -4/3/21, 4/12/21, 4/19/21 montelukast 5 mg were not documented as administered. 4/14/21 was documented on 4/15/21 as not administered, patient refused. -4/3/21, 4/19/21 8pm doses of Aripiprazole 15mg were not documented as administered. -4/2/21, 4/11/21, 4/19/21 8pm dose fluticasone-salmeterol 100 mcg-50mcg powder was not documented as administered. 4/14/21, 4/23 8pm dose was documented as not administered patient refused. -3/13/13 (5pm), 3/17/21 (7am, 5pm) doses of lactase 3000 units were not documented as administered. 3/18/21(11am), 3/21/21 (11am, 5pm), 3/23/21 (11am), 3/24/21 (7am), 3/25/21 (5pm), 3/26/21 (11am), 3/29/21 (7am, 11am), 4/1/21 (11am, 5pm), 4/2/21 (7am, 5pm), 4/6/21 (11am, 5pm), 4/14/21 (11am), 4/20/21 (7am, 11am), 4/24/21 (5pm), 4/26/21, 4/27/21, 4/28/21 (11am, 5pm) were documented as not administered, patient refused. -4/19/21 8pm dose of venlafaxine extended release 150mg was not documented as administered. Interview on 5/5/21 client #5 stated: -She had been at the facility for 8 months. -She takes her medications. -The facility always had her medications.	V 118		

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V 118	Continued From page 13 Finding #6 Review between 5/3/21 and 5/5/21 of FC #6's record revealed: -15 year old female. -Admission date 9/25/20. -Discharge date 4/23/21. -Diagnoses of Disruptive Mood Dysregulation Disorder, PTSD, and ADHD. Review between 5/3/21 and 5/5/21 of FC #6's medication orders and order dates revealed: -Medications ordered 9/26/20 Aripiprazole 30mg daily for mood was discontinued on 3/3/21. -11/14/20: omega-3 polyunsaturated fatty acids daily for increase triglycerides. -2/20/21: bacitracin-neomycin-polymyxin B topical 400 units - 3.5- 5000 units twice daily for Xeroderma. -1/26/21: trazodone 25mg at bedtime for Insomnia. Review between 5/3/21 and 5/5/21 of FC #6's MARs from 3/6/21 through 4/23/21 revealed: -4/12/21 omega-3 polyunsaturated fatty acids was documented as not administered, drug not available. -3/14/21 (8am), 3/20/21 (8am), 3/21/21 (8am), 3/23/21 (8pm), 3/24/21 (8am), 3/25/21 (8am), 4/2/21 (8am), 4/3/21 (8am), 4/5/21 (8am, 8pm), 4/7/21 (8am, 8pm), 4/8/21 (8am), 4/10/21 (8am), 4/12/21 (8am, 8pm), 4/14/21 (8pm), 4/16/21 (8am), 4/17/21 (8am), 4/18/21 (8am), 4/19/21 (8pm), 4/21/21 (8pm), 4/23/21 (8am) bacitracin-neomycin-polymyxin B topical 400 units - 3.5- 5000 units were documented as not administered, patient refused. 4/15/21 was not documented as administered. -3/13/21 trazodone 25 mg was not documented as administered.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 118	Continued From page 14 -Aripiprazole 30mg continued to be administered daily from 3/3/21 until 3/15/21. Interview on 5/5/21 the Nurse Educator stated: -She had been instrumental in the implementation of the electronic MAR in March 2021. -No one had suggested they print a copy of an electronic MAR to review for documentation during the system change. -She was not aware of the issues with documentation identified during the survey. Interview on 5/5/21 with the Director of Nursing revealed: -The facility had transitioned from paper MARs to an electronic MAR in March 2021. -There had been problems with arm bands failing to scan when the nurse was administering medications. If the arm band had been damaged or wet it may not scan. -If the arm band failed to scan, none of the medications would be documented electronically that were to be given at that dosing time. -If a client's arm band would not scan the nurses would give the medication, but there was not a process/procedure for nurses to document this administration as part of the MAR. -The documentation for client #4, "Drug not available" was over a week end when the pharmacy was not on site and they had run out of the medication. -She believed the one time orders for client #4 (Thorazine and Benadryl) would have been administered, but the nurse failed to document. -She could not tell why client #3's Vitamin D order had not been transcribed/administered. She looked to see if the mother had refused to sign a consent, but there was no form found on his record to document the mother had been contacted for consent.	V 118		

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V 118	Continued From page 15 -It appeared that when nurses made a comment, the time of the comment would post under the "administered" column of the printed MAR. They would look at this system process. She had not seen this before reviewing the MARs with the surveyor. -She and the Nurse Educator would address the MAR issues identified. Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician. This deficiency has been cited 5 times since the original cite on 2/13/19 and must be corrected within 30 days.	V 118		
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted. . This Rule is not met as evidenced by: Based on record reviews, observations, and interviews, the facility failed to report medication	V 123	V123 The Director of Nursing is re-training 100% of the Nurses on the expectation of reporting any med errors immediately to the Physician and Pharmacist via the Medication Variance Report, to include medications not administered as scheduled. The Medication Variance Report is generated by the Nurse, Pharmacist, or other provider who identifies a medication variance. All Nurses will sign an attestation of understanding of this training. The Director of Nursing is re-training all Nurses on the expectation of documenting reasons in the eMAR for any medications not administered as scheduled. All Nurses will sign an attestation of understanding of this	6-7-21

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V 123	Continued From page 16 errors immediately to a physician or pharmacist. The findings are: Finding #1: Reviews between 5/3/21 and 5/5/21 of client #4's record revealed: -15 year old male. -Admission date 3/9/21. . -Diagnoses included post traumatic stress disorder (PTSD), anxiety, conduct disorder; attention deficit hyperactive disorder (ADHD); borderline intellectual functioning. -Medications ordered 3/9/21 included: Depakote DRT (delayed release tablet) 500 mg (milligrams) twice daily for mood; Buspar 5 mg twice daily for anxiety; Zyprexa 5 mg at bedtime for mood.; Vyvanse 30 mg daily for ADHD. -No documentation medications not given on 3/22/21, 4/10/21, 4/11/21 or 4/13/21 had been reported immediately to a physician or pharmacist. Reviews between 5/3/21 and 5/5/21 of client #4's medication administration records (MARs) from 3/9/21 through 5/3/21 (11 am) revealed: -3/22/21, 8 pm MAR entries for Buspar 5 mg, Depakote DRT 750 mg, and Zyprexa 5 mg read, "pt. (patient) asleep from IM (intramuscular) injections given earlier. -4/10/21, 4/11/21, and 4/13/21, 8am MAR entries for Vyvanse 30 mg read, "Not administered...Drug not available." Finding #2: Reviews between 5/3/21 and 5/5/21 of client #3's record revealed: -16 year old male. -Admission date 3/19/21. . -Diagnoses included mood Dysregulation	V 123	training. The Director of Nursing is re-training all Nurses on first-dose administration of medication and removing these from a Pyxis machine if not yet available in the patient's personal medication supply. The Director of Nursing is training all Nurses on the expectation of calling the Physician for instructions if a medication is not available. Any Nurse not having received this training by the June 7, 2021 target date will not be eligible to work until this training is received. Completion of the Medication Variance Report requires notification of the prescriber, the Director of Quality & Risk Management, the Director of Nursing, and the Director of Pharmacy. Trend data from these reports are reported by the Director of Pharmacy monthly to the Quality Council and the Medical Executive Committee and quarterly to the Pharmacy & Therapeutics Committee and the Governing Board. The Nurse Educator will be responsible for addressing any medication variances with the Nurse who generated the variance and the Director of Nursing will be responsible for ensuring that the Physician and Pharmacist are notified. The Director of Nursing will be responsible for reporting any medication variances and their corresponding notifications to the Physician and Pharmacist to the CEO in the daily Safety meeting, and this will be documented in the Safety meeting minutes.	

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V 123	Continued From page 17 disorder. -Medications ordered 3/19/21 included Strattera 80 mg and Vyvanse 30 mg every morning for ADHD. -Order dated 4/15/21, 9 packs of Miralax in 64 ounces of Gatorade this am, drink within 1 hour, -Order dated 3/28/21, 2000 units of Vitamin D daily for vitamin deficiency. -No documentation the physician or pharmacist had been notified immediately of client #3's refusal of Miralax on 4/15/21, or missed doses of medications on 4/2/21 and 4/14/21 because client #3 was not available. Review on 5/4/21, and 5/5/21 of client #3's MARs from 3/19/21 through 5/3/21 (11 am) revealed: -Miralax ordered on 4/15/21 was not transcribed on the MAR. -2000 units of Vitamin D daily had not been transcribed on the MARs and had not been documented as administered. -4/2/21 and 4/14/21, 8am MAR entries for Strattera 80 mg and Vyvanse 30 mg read, "Not administered...Patient not available." Observations on 5/5/21 at 4:40 pm revealed there was no Vitamin D 2000 units on hand for client #3. Finding #3 Review between 5/3/21 and 5/5/21 of client #5's record revealed: -15 year old female -Admission date -Diagnoses of PSTD unspecified, Oppositional Defiant Disorder Moderate and Asthma. -Medications ordered 8/29/20 included fluticasone nasal spray twice daily for allergies, montelukast 5 mg at bedtime for allergies. and fluticasone-salmeterol 100 mcg - 50mcg powder	V 123	The Director of Nursing will generate a Medication Omission Report daily from the eMAR and report any discrepancies to the CEO in the daily Safety meeting. The Medical Director is providing education to the medical staff regarding the expectations of the Nursing staff and their mandatory reporting to the Physician and Pharmacist. The Director of Nursing and Director of Pharmacy will monitor these processes to ensure compliance. The Director of Nursing will monitor this process daily and will be responsible for addressing any discrepancies with the Nursing staff.	

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V 123	Continued From page 18 1 puff twice daily for asthma. Review between 5/3/21 and 5/5/21 of client #5's MARs from 3/9/21 through 5/3/21 (11 am) revealed: -4/2/21, fluticasone 2nd dose documented as not administered, not available. 4/11/21 not documented as administered. 4/14/21 documented on 4/15/21 not administered Patient refused. Documented as administered once on 4/19/21 and 3 times on 4/20/21. 4/23/21 not administered Patient refused. -4/3/21, 4/12/21, 4/19/21 montelukast 5 mg were not documented as administered. 4/14/21 documented on 4/15/21 as not administered, patient refused. -4/2/21, 4/11/21, 4/19/21 8pm dose fluticasone-salmeterol 100 mcg-50mcg powder was not documented as administered. 4/14/21, 4/23 8pm dose was documented as not administered patient refused. Finding #4 Review between 5/3/21 and 5/5/21 of Former client (FC) #6's record revealed: -15 year old female. -Admission date 9/25/20. -Discharge date 4/23/21. -Diagnoses of Disruptive Mood Dysregulation Disorder, PTSD, and ADHD. -Medications ordered 9/26/20 Aripiprazole 30mg daily for mood was discontinued on 3/3/21. -Order date 11/14/20 omega-3 polyunsaturated fatty acids daily for increase triglycerides. -Order date 2/20/21 bacitracin-neomycin-polymyxin B topical 400 units - 3.5- 5000 units twice daily for Xeroderma. Review between 5/3/21 and 5/5/21 of FC #6's MARs from 3/6/21 through 4/23/21 revealed:	V 123		

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V 123	Continued From page 19 -Aripiprazole 30mg continued to be administered daily from 3/3/21 until 3/15/21. -4/12/21 omega-3 polyunsaturated fatty acids was documented as not administered, drug not available. -3/14/21 (8am), 3/20/21 (8am), 3/21/21 (8am), 3/23/21 (8pm), 3/24/21 (8am), 3/25/21 (8am), 4/2/21 (8am), 4/3/21 (8am), 4/5/21 (8am, 8pm), 4/7/21 (8am, 8pm), 4/8/21 (8am), 4/10/21 (8am), 4/12/21 (8am, 8pm), 4/14/21 (8pm), 4/16/21 (8am), 4/17/21 (8am), 4/18/21 (8am), 4/19/21 (8pm), 4/21/21 (8pm), 4/23/21 (8am) bacitracin-neomycin-polymyxin B topical 400 units - 3.5- 5000 units was documented as not administered, patient refused. 4/15/21 was not documented as administered. Interview on 5/6/21 the Internal Medicine Provider stated: -She was not aware that client #3 had not received his vitamin D she ordered 3/23/21. No one had reported to her that it had been identified 5/5/21 as not having been given. -There was a new MAR documentation system and it was more difficult for her to see what clients were taking compared to the old system. -She could not recall being told client #3 refused to take the Miralax ordered on 4/15/21. He had been "doubled over" in pain and he was sent to hospital. Sometimes the clients would refuse this medication. -It seemed like some of the medications did not "transfer" when they changed MAR systems during the first couple of days. She thought this had been fixed and had not noticed any problems recently. Interview on 5/5/21 with the Director of Nursing revealed: -The facility had transitioned from paper MARs to	V 123		

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V 123	Continued From page 20 an electronic MAR in March 2021. -If a client refused a medication they would not necessarily contact the pharmacy or ordering provider, it would depend on the medication. The nurse should document the refusal in the nursing notes. -The documentation for client #4, "Drug not available" was over a week end when the pharmacy was not on site and they had run out of the medication.	V 123		
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	V 314 Appointments for outside medical treatment will be made at the earliest available opportunity. In order to ensure that necessary patient care is coordinated with other individuals or agencies in the catchment area, the Director of Nursing and Staffing Coordinator will review the appointment log weekly and consult with the Physicians/Medical Providers whenever appointments for necessary care are not available within the local community. If a timely appointment is not available and it is determined by the Physician that medical care is urgent, the Physician may order the patient referred to the local Emergency Room. The Director of Nursing and the Staffing Coordinator will meet weekly to review the appointment log and the status of outside medical consultation completion. The Director of Nursing will provide a weekly report on this status to the CEO in the Safety meeting. The Scheduling Coordinator will work with	6-7-21

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V 314	Continued From page 21 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 reviews and interviews, the facility failed to coordinate care with other individuals and agencies within the catchment area for 2 of 5 current clients audited (client #3, client #4). The findings are: Finding #1: Reviews between 5/3/21 and 5/5/21 of client #4's record revealed: -15 year old male. -Admission date 3/9/21. . -Diagnoses included post traumatic stress disorder (PTSD), anxiety, conduct disorder; attention deficit hyperactive disorder (ADHD); borderline intellectual functioning -Referral order dated 3/7/21 to an orthopedic physician; diagnosis was "displaced" fracture, 4th metatarsal bone, left foot.	V 314	the Milieu Managers to provide appropriate staffing for outside medical appointments. The Staffing Coordinator will discuss staffing for urgent appointments with the Director of Nursing. The Medical Director is providing education to the medical staff regarding the expectations of the Nursing staff and their mandatory consultation with the Physician. The Director of Nursing will be responsible for monitoring this process. The Director of Nursing will monitor this process weekly and report on patient transports and any discrepancies in the provision of off-site medical care weekly to the CEO in the Safety meeting.	

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	MHH0976	A. BUILDING: _____ B. WING _____	05/10/2021

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V 314	Continued From page 22 -Admission orders dated 3/9/21 included order for close observations "while using crutches." -3/26/21: Client #4 was seen by Urgent Care provider for closed, non-displaced fracture of his 5th metatarsal bone in his right hand; splint was applied. -4/1/21: Client #4 was seen by an orthopedic provider for his right hand fracture; cast was applied. Follow up appointment made for 4/29/21. -4/29/21: Client #4 was seen by orthopedic provider for follow up for hand fracture. -No documentation client #4 was seen by an orthopedic provider for his left foot fracture. Review on 5/3/21 and 5/4/21 of client #4's History and Physical dated 3/10/21 revealed: -Client #4 sustained a fracture of his 4th toe approximately 3 weeks prior to admission. -He was given crutches on 3/8/21, but was not using them. -Client #4 was suppose to have been seen the day prior to admission an orthopedic provider for a "boot." -Physician ordered client #4 to be seen "ASAP" (as soon as possible) by orthopedics, crutches, and supportive care. Interview on 5/5/21 client #4 stated: -When he was admitted he had fractured his foot (fractured prior to admission). -He was supposed to have been using crutches. -After he was admitted they took his crutches. -His foot was not in a splint. -He had pain in his foot for a few days. -Staff gave him Ibuprofen for the pain and melatonin to help him sleep. Interview on 5/5/21 Milieu Manager #2 stated: -He was not aware client #4 had a foot fracture when he was admitted.	V 314		

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V 314	Continued From page 23 -The nurse would have known this and documented. -He remembered when client #4 was admitted he was on activity restrictions. -His restrictions were he was able to walk or sit, but he was "running around and not complaining of pain." -He did not recall any crutches. Interview on 5/5/21 the Director of Nurse stated client #4 had been seen by an orthopedic physician on 4/1/21 and 4/29/21. Finding #2: Reviews between 5/3/21 and 5/5/21 of client #3's record revealed: -16 year old male. -Admission date 3/19/21. -Diagnoses included mood Dysregulation disorder -4/14/21 client #3 was sent to the emergency room (ER) via EMS (Emergency Medical Service) to rule out appendicitis. He was diagnosed with constipation; discharge order to begin taking Miralax. -4/15/21 client #3 was seen by internal medicine provider and ordered a clear liquid diet until further notice; Miralax 9 packs in 64 ounces of Gatorade, drink within 1 hour. Order included to notify provider via consult book when patient had brown liquid stools, no "chunks." -Order dated 3/28/21, 2000 units of Vitamin D daily for vitamin deficiency. -Internal Medicine Provider consultation dated 4/27/21 documented, client #3 complained of right hand cast discomfort. He had missed his orthopedic follow up appointment on 4/21/21 due to staffing. He was re-scheduled for 5/5/21. Cast was " Rubbing/ chaffing to mid cast region." Plan/Order "get taken off ASAP if approved by	V 314		

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V 314	Continued From page 24 Ortho ..." Review on 5/4/21, and 5/5/21 of client #3's Medication Administration Records (MARs) from 3/19/21 through 5/3/21 (11 am) revealed: -Order dated 4/15/21 for Miralax was not printed on the MARs. -Order dated 3/28/21 for 2000 units of Vitamin D daily was not printed on the MARs. Interview on 5/5/21 client #3 stated: -He had been taken to the ER by EMS for abdominal pain. -He refused to take the "stuff" the staff wanted him to take (Miralax in Gatorade). -He refused because he was hungry and wanted to eat. -He understood he could not eat and take this medication. Interview on 5/5/21 the Director of Nursing stated: -Guardians/parents were contacted for consent prior to giving newly ordered medications. She could not find the form in client #3's record where his mother had been contacted about the vitamin D order. -Client #3 refused the Miralax ordered 4/15/21. When clients refused medications, it depended on the medication as to whether the physician was contacted. -She was not sure if the physician was notified when client #3 missed his orthopedic appointment on 4/19/21 due to staffing shortages. Interview on 5/6/21 the Internal Medicine Provider stated: -She or someone from her practice was on site daily to address medical problems. -Her practice would see consults and do follow up visits. On the week ends the providers did more	V 314		

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V 314	Continued From page 25 visits for acute issues. -She was not aware that client #3 had not received his vitamin D (ordered 3/23/21). No one had reported to her that it had been identified 5/5/21 as not having been given. Her note dated 3/29/21 about her follow up and it being tolerated was probably based on interview with the client. Typically when she rounded on the clients she would ask how they are doing, and he probably would have said "ok." She would typically ask nurses if the clients were taking their meds and they probably said "yes" when asked. -She could not recall being told client #3 refused to take the Miralax she ordered 4/15/21. He had been "doubled over" in pain and had been sent to the hospital. -She remembered client #3 missed his orthopedic appointment due to staffing. She found out when she made a follow up visit. His cast was causing him discomfort. -It happened often that clients missed appointments due to staffing. When this happened the staff did not notify her. -She did not recall a lot about client #4's foot fracture on admission. He told her he was supposed to be in a boot. She preferred they stay off a lower extremity until it was x-rayed. She was even more concerned with hand fractures. -She always wanted the client sent/seen by orthopedics for fractures. The orthopedic practice they refer to has "walk-in" appointments if needed. -Neither client #3 or client #4 had suffered any adverse outcomes for their fractures. This deficiency was cited 3 times on 3/20/19, 5/30/19, and 10/15/19.	V 314		

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V 315	Continued From page 26	V 315		
V 315	27G .1902 Psych. Res. Tx. Facility - Staff 10A NCAC 27G .1902 STAFF (a) Each facility shall be under the direction a physician board-eligible or certified in child psychiatry or a general psychiatrist with experience in the treatment of children and adolescents with mental illness. (b) At all times, at least two direct care staff members shall be present with every six children or adolescents in each residential unit. (c) If the PRTF is hospital based, staff shall be specifically assigned to this facility, with responsibilities separate from those performed on an acute medical unit or other residential units. (d) A psychiatrist shall provide weekly consultation to review medications with each child or adolescent admitted to the facility. (e) The PRTF shall provide 24 hour on-site coverage by a registered nurse. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure at least 2 direct care staff were present with every 6 children or adolescents at all times. The findings are: . Interview on 5/05/21 client #6 stated: - She had been at facility for approximately 8 months. - There were usually 3-4 staff working per shift. - There were times where as few as 2 staff were working a hall the entire shift. - There were 11 residents on her hall.	V 315	V 315 In order to ensure that a 2:6 direct care staff to patient ratio is maintained at all times, the Director of Nursing and Milieu Director will report daily to the CEO in the Safety meeting the number of staff scheduled for that day and the following day. To help stabilize facility staffing, the administration has approved a significant increase to the starting salary for the MHT position. The Lead MHTs have been empowered to offer critical shift incentive pay to help cover vacant MHT shifts. A central call-out phone is being provided which is answered by a Lead MHT to ensure that coverage for the vacant shift is obtained in a timely manner. In the event of an unforeseen staff vacancy, the Milieu Manager will notify the designated MHT(s) that they must stay until appropriate relief can be obtained. The Lead MHTs are responsible for obtaining this relief coverage The facility is using OnShift scheduling software to communicate with employees through blast messages regarding vacant shifts. The Milieu Manager will monitor staffing ratio compliance and report to the CEO twice daily with an update the following day. The Milieu Manager is responsible for maintaining the appropriate 2:6 direct care	6-7-21

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V 315	Continued From page 27 - There could be as many as 18 residents per hall. Interview on 5/05/21 client #2 stated: - There were 3-4 staff working per shift depending on whether they were short staffed. - There were always at least 3 staff per shift. - There were generally 10-12 residents per hall. - There had been as many as 16 residents on a hall with only 3 staff working. - There was miscommunication between staff on 4/20/21 which resulted in an absence of staff on her hall for about 7 minutes. Interview on 5/05/21 client #4 stated: - He had been at facility for approximately 3 months. - There were 3-4 staff working per shift. - There were 16 residents on his hall. Interview on 5/05/21 client #1 stated: - She had been at facility for approximately 2.5 months. - There were 3-4 staff working per shift. - There were 10 residents on her hall. Interview on 5/05/21 staff #1 stated: - She had worked at facility for approximately 1 year. - There were 3 staff working per shift. - There were 12 clients on her assigned hall. - There were times where it may be 2 staff working until the 3rd person came in to relieve them. Interview on 5/05/21 staff #2 stated: - She had worked at facility for approximately 6 months. - There were 4-6 staff working per shift. - There were as many as 18 clients on a hall.	V 315	staff to patient ratio. The Milieu Manager will monitor this process daily and report any discrepancies and corrective action to the CEO in the Safety meeting.	

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V 315	Continued From page 28 - There were times where there may be as few as 3 staff per 12 residents. Interview on 5/05/21 Milieu Manager #2 stated: - He had worked at facility for approximately 3 years. - Attempts were made to keep 4 staff on per shift. - There were times where there were as few as 3 staff working per shift. Interview on 5/06/21 Internal Medicine Provider stated: - She worked with an outside medical agency. -She remembered client #3 missed his orthopedic appointment on 4/21/21 due to staffing. She found out when she made a follow up visit. His cast was causing him discomfort. - Missed medical appointments due to staffing was something that happened often. Interview on 5/07/21 Milieu Manager #1 stated: - There was an average of 4-5 staff working per unit. - There had been as few as 3 staff working per unit. - There had been 1 or 2 times recently where a client had missed an appointment due to a lack of staffing.	V 315		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs	V 366	V 366 In order to ensure that written policies and procedures governing the facility's response to level I and II incidents are implemented as required, the Director of Nursing will require a daily report from each unit's Nurse regarding the medical care of all patients following a level I or II incident.	6-7-21

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V 366	Continued From page 29 of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The	V 366	The Director of Nursing will provide a summary of the daily reports on medical care of patients following level I or II incidents to the CEO in the daily Safety meeting. The Director of Nursing will monitor these processes and provide a daily report to the CEO in the Safety meeting, which will be documented in the meeting minutes. The Director of Quality & Risk Management will also monitor this process to ensure it is sustained. The Director of Nursing will monitor this process daily and report any discrepancies and corrective action to the CEO in the Safety meeting.	

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V 366	Continued From page 30 internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility	V 366		

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V 366	Continued From page 31 for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to implement written policies governing their response to level I and II incidents as required. The findings are: Finding #1: Reviews between 5/3/21 and 5/5/21 of client #4's record revealed: -15 year old male. -Admission date 3/9/21. . -Diagnoses included post traumatic stress disorder (PTSD), anxiety, conduct disorder; attention deficit hyperactive disorder (ADHD); borderline intellectual functioning. -On 3/26/21 client #4 was sent to Urgent Care for a closed, non-displaced fracture of his 5th metatarsal bone in his right hand; splint was applied. -On 4/1/21 seen by orthopedic provider and cast applied to his right hand. Review on 5/5/21 of level I incident reports and Medication Administration Records (MARs) for client #4 revealed no level I incident reports for the following:	V 366		

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V 366	Continued From page 32 -3/22/21, 8 pm scheduled doses for Buspar 5 mg (milligrams), Depakote DRT (delayed release tablet) 750 mg, and Zyprexa 5 mg were not administered; nurse documented "pt. (patient) asleep from IM (intramuscular) injections given earlier. -4/10/21, 4/11/21, and 4/13/21, 8 am scheduled doses for Vyvanse 30 mg were not administered; nurse documented , "Not administered...Drug not available." Review on 5/5/21 of level II incident reports for client #4 revealed his fractured right hand incident had not been documented as a level II incident. Finding #2: Reviews between 5/3/21 and 5/5/21 of client #3's record revealed: -16 year old male. -Admission date 3/19/21. -On 4/1/21 xrays identified a fracture of the 5th distal metacarpal bone, right hand and was seen 4/2/21 by an orthopedic provider and had a cast was applied. Review on 5/5/21 of level I incident reports and MARs for client #3 revealed no level I incident reports for the following: -4/2/21 and 4/14/21, 8am scheduled doses for Strattera 80 mg, Vyvanse 30 mg, and benzoyl peroxide 10% topical acne wash were not administered; nurse documented, "Not administered...Patient not available." -4/15/21 order for 9 packs of Miralax in 64 ounces of Gatorade this am, drink within 1 hour, not documented on the medication administration record (MAR). -3/24/21 order for daily benzoyl peroxide 10% topical acne wash, scheduled for 8am, was documented "Patient Refused," 11 days in April	V 366		

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V 366	Continued From page 33 2021 and on 5/1/21. Review on 5/5/21 of level II incident reports for client #3 revealed his fractured right hand incident had not been documented as a level II incident. Interview on 5/5/21 client #3 stated he refused the Miralax on 4/15/21. Refer to Tags V367 and V123 for additional information. This deficiency has been cited 3 times since the original cite on 5/30/19 and must be corrected within 30 days.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information;	V 367	V 367 The vacant position that contributed to this deficiency has been filled as of May 3, 2021. In order to ensure that level II incidents are submitted to the Local Management Entity (LME) within 72 hours as required, the new Director of Quality & Risk Management has established a tracking checklist to ensure that all Level II incidents are reported daily in IRIS by the staff in the Quality & Risk Management Department. The Director of Quality & Risk Management is verifying daily that the IRIS reports have been submitted and reporting this to the CEO in the daily Safety meeting. This is documented in the Safety meeting minutes. The Director of Quality & Risk Management will review on a daily basis the data entry of any level II reportable incidents into IRIS as performed by the staff in the Quality & Risk Management	6-7-21

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	MHH0976	A. BUILDING: _____ B. WING _____	05/10/2021

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

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V 367	Continued From page 34 (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the	V 367	Department. A column has been added to the incident report tracking spreadsheet for the IRIS tracking number. This has also been added to the investigation tracking checklist that accompanies any investigation to trigger the reporting of any incident that may become elevated to a Level II upon further investigation. The Director of Quality & Risk Management is responsible to monitor the process. The Director of Quality & Risk Management will report daily on weekdays to the CEO in the Safety meeting the status of the previous day's incident reporting to IRIS. The status of the reporting due on Friday through Sunday will be reported on Mondays.	

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V 367	Continued From page 35 catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure Level II incident reports were submitted to the Local Management Entity (LME) within 72 hours as required. The findings are: Finding #1: Reviews between 5/3/21 and 5/5/21 of client #4's record revealed: -15 year old male. -Admission date 3/9/21. . -Diagnoses included post traumatic stress	V 367		

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V 367	Continued From page 36 disorder (PTSD), anxiety, conduct disorder; attention deficit hyperactive disorder (ADHD); borderline intellectual functioning -On 3/26/21 client #4 was sent to Urgent Care for a closed, non-displaced fracture of his 5th metatarsal bone in his right hand; splint was applied. -On 4/1/21 seen by orthopedic provider and cast applied to his right hand. Review on 5/4/21 of the North Carolina Incident Response Improvement System (IRIS) reports between 3/26/21 and 5/4/21 revealed no Level II incident report for client #4's right hand fracture. Finding #2: Reviews between 5/3/21 and 5/5/21 of client #3's record revealed: -16 year old male. -Admission date 3/19/21. -Diagnoses included mood Dysregulation disorder -On 3/31/21 client #3 punched a window with his right hand. On 4/1/21 xrays identified a fracture of the 5th distal metacarpal bone, right hand. -4/2/21 client #3 was seen by an orthopedic provider and a cast was applied to his right hand. Review on 5/4/21 of the IRIS reports between 4/1/21 and 5/4/21 revealed no Level II incident report for client #3's right hand fracture.	V 367		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive	V 736	V 736 The Interim Director of Plant Operations has coordinated outside vendors to clean and paint as needed in all PRTF patient bedrooms. All patient bedrooms will be cleaned and painted as needed by June 7 and this was verified by the Chief	6-7-21

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V 736	Continued From page 37 odor. This Rule is not met as evidenced by: Based on observations and interviews, the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are: Observations of the facility on 5/03/21 at approximately 1:30pm revealed: -Room #106 had paint chipping from the doorway upon entering the bathroom. There were markings written in crayon on a wall in the bathroom. -Room #109 had profanity and numerous words written in crayon across all four walls of the bathroom. -100 Hall Day Room sofas missing 2 back cushions. -Room #205 There was no shower curtain in the bathroom. -Room # 302 had markings written in crayon on the walls in the bathroom. -There were markings written in crayon on the hallway wall between room #304 and room #306. -Room 304: Unfinished wall repair in the bathroom. Area thickly spackled with compound, not sanded and not painted. Writing on walls to include, "I'm a loser" written beside the bed to left on entry. Client #1 lying on this bed. -Room #307 There was no shower curtain in the bathroom. The bedroom door was broken near the handle along the frame near the lock about 12 inches long exposing the wood underneath. -Room #308 The bedroom door was split near the door handle approximately 6 inches exposing the plywood.	V 736	Financial Officer. Cushions have been ordered to replace identified missing dayroom furniture cushions. Due to the lead time on the cushion replacement order, two of the dayrooms have been temporarily closed in order to consolidate dayroom furniture cushions so that all dayroom furniture in use has adequate furniture cushions. This reduction in dayroom capacity does not compromise activity schedules of patients on these two halls due to their reduced census. Patient bedroom doors identified as in need of replacement due to damage have been ordered. Orders for replacement of other doors will be placed as needed prior to June 7, 2021. To ensure that damaged doors are replaced in a timely manner, this item has been added to the daily Environmental Checklist. An inspection of all facility doors has also been added to the weekly Environment of Care survey of the facility (the "Pristine survey") performed by the Director of Plant Operations and Chief Financial Officer. A new system has been established where the Milieu Manager Reports and Environmental Checklists are sent to the Executive Assistant to the CEO on a daily basis (checklists from Friday through Sunday will be submitted on Mondays). The Executive Assistant to the CEO is inputting maintenance work orders directly from these reports into the TELS work order tracking system for any necessary maintenance.	

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V 736	Continued From page 38 -Room 401: Blotches of a dried white substance were spread over 3 of the 4 walls. Writing and graffiti on the walls to include a Satanic symbol, a 5 pointed star in a circle, drawn on the wall beside the bed on the left when entering room; a Swastika symbol drawn on the wall directly across from this bed, on the wall to one's right when entering the room. -Room #402 had a piece of plywood approximately 6' x 4' covering a hole in the bathroom wall where the drywall had been removed. Dabs of toothpaste were observed along the walls of the bedroom. -Room #403 had a piece of plywood approximately 6' x 4' covering a hole in the bathroom wall where the drywall had been removed. A strip of border approximately 6" in width had been removed on the bathroom wall. The missing strip was to the right of the toilet and extended from the floor tile all the way up the wall. Dabs of toothpaste were observed along the walls of the bedroom. -Room #404 had markings written in crayon on the walls in the bedroom. -Room #407 had several dried tissue pieces that were once wet on the ceiling and all walls approximately 18 different spots. -Room #406 The bathroom had a piece of plywood approximately 6' x 4', unpainted along long. The bedroom had a several white sticky substances in the shape of a triangle approximately 2' x 1'. -2 seclusion rooms: Writing on the walls, to include profanity, (F___k); paint worn off the surface of the doors. Interview on 5/3/21 client #10 stated: -She did not write "I'm a loser" on the wall beside her bed. -This was written on the wall when she had been	V 736	The Milieu Director coordinated all Milieu Managers holding groups with all PRTF patients to communicate expectations regarding bedroom cleanliness. The Milieu Director has established a recurring "Cleanest Room of the Week Award" and a "Cleanest Hallway of the Week Award" to incentivize patients to maintain clean rooms and minimize graffiti. The groups were conducted with all PRTF patients by May 14, 2021. The "Cleanest Room of the Week Award" and a "Cleanest Hallway of the Week Award" were implemented on May 19, 2021. The Housekeeping department continues to maintain a routine cleaning schedule for all patient bedrooms/ bathrooms and common areas. The Director of Plant Operations will monitor these processes to ensure that the facility and its grounds are maintained in a safe, clean, attractive manner and kept free from offensive odor. The Chief Financial Officer will review all open work orders in the TELS system weekly with the Director of Plant Operations to prioritize the work and ensure that the work is done timely and that completed items are removed. The Director of Plant Operations and Chief Financial Officer will complete an Environment of Care survey of the facility weekly (the "Pristine survey") and provide it weekly to the CEO and monthly to the Quality Council.	

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V 736	Continued From page 39 admitted. -When asked if this had bothered her, she stated it had not. Interview on 5/03/21 the Staff #3 stated: -He was the Lead staff working on the 400 Hall. -The staff did room checks daily. -Room checks included looking for contraband and putting in work orders for needed repairs. -He thought Staff #4 had completed the room checks for 5/3/21. Interview on 5/03/21 Staff #4 stated he had not completed the daily room checks for the shift. Interview on 5/3/21 during facility tour Milieu Manager #1 stated: -Client #1 had punched a hole in the shower wall, room #303. A work order had been submitted and they had recently received approval for repair. -A client had punched a hole in the bathroom wall in room #304. He was not sure which client punched the wall. -The blotches of dried white substance on the room walls, i.e. room 401, were dried tooth paste used by clients as glue to post items onto the walls. -A work order was submitted to repair the doors of rooms #307 and #308. -Room #407 would be cleaned as soon as possible. He was not aware of spots of tissue. This deficiency has been cited 5 times since the original cite on 2/13/19 and must be corrected within 30 days.	V 736		
V 750	27G .0304(b)(3) Maintenance of Elec., Mech., & Water Systems	V 750	V 750 A new system has been established	6-7-21

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V 750	Continued From page 40 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (3) Electrical, mechanical and water systems shall be maintained in operating condition. This Rule is not met as evidenced by: Based on observations, record review, and interviews, the facility's water systems failed to be maintained in operating condition. The findings are: Observations on 5/03/21 at approximately 1:30 pm revealed: - Room 109 had a shower head with steady stream of water running from it while not tuned on. - Room #207 had a missing water faucet knob in the bathroom shower. - Room 303 shower was out of order. Review on 5/3/21 of work order #18840 revealed: -3/23/21 client #1 kicked a hole in the shower wall in room 303. -Shower needed to be replaced; a door was put on the bathroom until it could be fixed. Interview on 5/5/21 client #1 stated: -She punched a hole in the bathroom and was put in seclusion. -Staff would give her permission to use a peer's bathroom to take a shower. -No one had offered to move her to a room with a	V 750	where the Milieu Manager Reports and Environmental Checklists are sent to the Executive Assistant to the CEO on a daily basis (checklists from Friday through Sunday will be submitted on Mondays). The Executive Assistant to the CEO is inputting maintenance work orders directly from these reports into the TELS work order tracking system for any necessary maintenance. The new work order system was implemented on May 6, 2021. The Chief Financial Officer and Director of Plant Operations will complete a weekly Environment of Care survey of the facility (the "Pristine survey") and submit it to the Director of Risk & Quality and the CEO for review and follow-up. Going forward, if a patient's bathroom must be taken off line for repair, the patient(s) will be relocated to another bedroom with a working bathroom until this priority repair is complete. The Environmental Checklists are reviewed in the daily Safety meeting by the Milieu Director, Director of Nursing, and Director of Plant Operations. The Chief Financial Officer and Director of Plant Operations will complete a weekly Environment of Care survey of the facility and submit it to the Director of Risk & Quality and the CEO for review and follow-up. The Director of Plant Operations and Chief Financial Officer are responsible for monitoring these processes.	

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V 750	Continued From page 41 working shower. -She liked staying in her bedroom and wanted the shower fixed.	V 750	The Director of Plant Operations and Chief Financial Officer will complete an Environment of Care survey weekly (the "Pristine survey") and provide it weekly to the CEO and monthly to the Quality Council.	

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

May 21, 2021

Steve McCabe, CEO
SBH-Wilmington, LLC
2050 Mercantile Dr.
Leland, NC 28451

Re: Annual, Complaint and Follow Up Survey completed May 10, 2021
Carolina Dunes Behavioral Health, 2050 Mercantile Dr., Leland, NC 28451
MHH0976
E-mail Address: steve.mccabe@strategicbh.com
derek.johnson@strategic.com
kaleb.norris@stregicbh.com
Intake #NC00176202

Dear Mr. McCabe:

Thank you for the cooperation and courtesy extended during the annual, complaint and follow-up survey completed May 10, 2021. The complaint was substantiated.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- Re-cited standard level deficiencies.
- Standard level deficiencies.

Time Frames for Compliance

- Re-cited standard level deficiencies must be ***corrected*** within 30 days from the exit of the survey, which is June 9, 2021.
- Standard level deficiency must be ***corrected*** within 60 days from the exit of the survey, which is July 9, 2021.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Gloria Locklear at 910-214-0350.

Sincerely,

Betty Godwin, RN, MSN
Nurse Consultant
Mental Health Licensure & Certification Section

Tareva Jones, MSW
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Ryan Meredith
Facility Compliance Consultant I
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