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November 15, 2021

VIA HAND DELIVERY AND SECURED ELECTRONIC MAIL

Michiele Elliott, Acting Chief
Mental Health Licensure & Certification Section
Division of Health Service Regulation
North Carolina Department of Health and Human Services
1800 Umstead Drive, Williams Building
Raleigh, NC 27603

Re: SBH-Raleigh, LLC, MHL #: MHH-0973; Response to Notice of Intent to Revoke License, Statement of Compliance with Licensure Rules

Dear Ms. Elliott:

I am writing on behalf of our client, SBH-Raleigh, LLC ("SBH-Raleigh"), with respect to the Notice of Intent to Revoke License ("Notice") dated November 4, 2021. The Notice is based on the findings in the Statement of Deficiencies ("SOD") for a survey completed October 26, 2021 by the Mental Health Licensure & Certification Section of the Division of Health Service Regulation ("DHSR" or "Agency").

Pursuant to the Notice, SBH-Raleigh was provided 10 calendar days to submit a written statement to the Agency stating that it believed it was in compliance with applicable laws and licensure rules.

Please consider this letter SBH-Raleigh's written statement that it is in compliance with applicable state laws and licensure rules. In addition, SBH-Raleigh requests an informal conference to meet with the Agency for the purpose of reviewing this statement and the documentation provided to demonstrate their commitment to sustaining compliance.

Submitted contemporaneously with this statement is the signed and dated Plan of Correction ("POC"). The facility also has on site and will make available supporting documentation for the respective corrective actions and other documentation to demonstrate the efforts being made at the facility and corporate levels to support SBH-Raleigh.

SBH-Raleigh has taken immediate and specific actions to correct the citations noted in the SOD. For example, some of those actions include:

- Immediate implementation of Plans of Protection;
- Development and implementation of a POC being submitted to DHSR contemporaneously with this letter;
- Review of policies and implementation of revisions as needed, including in the following areas:
    - Incident reporting;
    - Staff Discipline;
    - Restraint/Seclusion;
- Completion of extensive trainings and re-trainings for all staff, including in the following areas:
    - Discharge process;
    - Medication orders;
    - Incident reporting;
    - Staff Discipline;

- Restraint/Seclusion (including orders);
- Alternatives to restrictive interventions (CPI);
- Roles and Responsibilities and Milieu Management;
- Responding and responsibilities in codes.

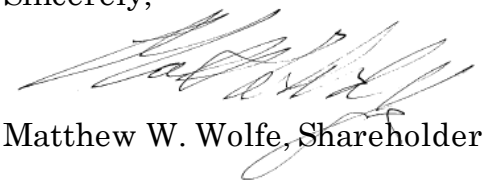
- All education has been added to New Hire orientation and New Provider/ Physician Orientation materials.
- Extensive and ongoing 100% audits and monitoring to ensure sustainable compliance.

In addition to the extensive and robust actions undertaken at the facility level, the corporate office has also undertaken efforts to support changes and enhancements at SBH-Raleigh. Their efforts have addressed areas including leadership, culture, staffing, systems and procedures, and sustainability. This support demonstrates their commitment to compliance, SBH-Raleigh, and its clients.

SBH-Raleigh is committed to compliance with applicable laws and licensure rules and believes that it has addressed all concerns identified by DHSR that would impact client health, safety, and welfare.

We look forward to the opportunity to meet with the Agency to review the above and the information provided with this submission. Additionally, SBH-Raleigh appreciates the opportunity to discuss its ongoing activities to maintain compliance and answer any questions that you may have.

Sincerely,



Matthew W. Wolfe, Shareholder

cc: Ms. Bethany Burgon (via email)
Ms. Evelyn Alsup (via email)

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 10/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVIORAL CENTER-GARNER	3200 WATERFIELD DRIVE GARNER, NC 27529

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V 000	INITIAL COMMENTS A Follow Up and Complaint survey was completed on 10/26/21. The complaints were substantiated (Intakes #NC00179281, #NC00179445, #NC00178447, #NC00180199, #NC00180904, #NC00181294, #NC00181505, #NC00181670, #NC00181771, #NC00181950, #NC00182159 and #NC00182653). Deficiencies were cited. This facility is licensed for the following service categories: - 10A NCAC 27G. 1900 Psychiatric Residential Treatment for Children and Adolescents. Halls 300, 400, 500 and 600 were licensed under this category - 10A NCAC 27G. 6000 Inpatient Hospital Treatment for individuals who have Mental Illness or Substance Abuse Disorders. Halls 100, 200, 700 and 800 were licensed under this category referred to as Acute Unit. A Sister Facility is identified in this report. The Sister Facility will be identified as Facility A. Sister Facility A is licensed for the following service category 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents. Staff will be identified using the letter A and their professional titles. This location will be identified as Strategic Behavioral Center-Garner in the report.	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:*** • What measures will be put in place to correct the deficient area of practice. • What measures will be put in place to prevent the problem from occurring again. • Who will monitor the situation to ensure it will not occur again. • How often the monitoring will take place. V 105 Begins 1) Policies were reviewed, and staff have been provided with re-education of the policies and processes.	
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:	V 105		

Received by MHL & C
11/30/2021

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V 105	Continued From page 1 (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 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;	V 105	V 105 Continues 2) Incident reporting processes have been reviewed, and we identified areas where improvements to the processes were immediately put in place to respond and complete any investigations accurately and timely. 3) Disciplinary processes have also been reviewed, and we identified areas where improvements to the processes were implemented immediately. 4) All education provided and referred to throughout this Plan of Correction has been added to New Hire orientation, with the next orientation class starting 11/15/21. 5) All education provided and referred to throughout this Plan of Correction has been added to New Provider/ Physician Orientation materials.	

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V 105	Continued From page 2 (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; This Rule is not met as evidenced by: Based on record review and interview the facility failed to follow its discharge policy and failed to implement written standards that assured operation and programmatic performance meeting applicable standards of practice for restraint and seclusion orders along with monitoring of the client in and immediately after restraint, assessment post seclusion or restraint and meeting training requirements for a staff involved in a seclusion and restraint incident. The findings are: A. Review on 10/21/21 of the facility discharge policy revealed: "Purpose- Discharge planning is an organized, coordinated process, with	V 105	V 105 Continues **Measures that will be put in place to correct the deficient area of practice:** Education on the discharge process for PRTF is being completed with all direct care staff. Education on the discharge process for PRTF is being completed with all physicians/ providers. RNs and therapists have been trained on ensuring physicians are ordering all discharges and transfers to other levels of care. Education on documentation of medication orders has been completed with nursing staff and providers/ physicians. Review of the Restraint/ Seclusion policies and processes were reviewed by Leadership. Re-education of restraint/ seclusion processes has been completed with all direct care staff. All direct care staff have been trained on all aspects of seclusion and restraint to include observations during and after interventions. Physician/ provider education has been provided on restraint/ seclusion documentation requirements including guidelines for restraint/ seclusion orders. Additional training on Restraint/ Seclusion, Roles and Responsibilities and Milieu Management, leadership roles, responding and responsibilities in codes. has been assigned quarterly to all direct care staff.	11/17/21 11/17/21 11/17/21 11/10/21 11/17/21 11/17/21 11/17/21 11/17/21

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V 105	Continued From page 3 multidisciplinary team, patient and family input, identifies the patient's needs after discharge, delineates plans to meet these needs and teaches the patient and family how to implement the plans. Discharge planning is an ongoing process which begins on admission and continues throughout the patients hospitalization. The planning is continually assessed and re-evaluated for appropriateness. Policy-Possible referrals included are Medical/Physician/provider, professional ancillary resources, home health agencies, nursing homes, medical clinic, group homes, halfway houses, and other hospitals or clergy services will be identified as needed, considering the individual's cultural and ethnicity, in the discharge plan. At the time of discharge, the licensed nurse completes the discharge instructions and summary" Review on 10/18/21 of Former Client (FC) #11 record revealed: - Admitted: 7/7/21 - Discharged: 7/21/21 - Diagnosis: Disruptive Mood Dysregulation Disorder - Age: 16 - "Patient observation rounds" sheet dated 7/17/21 listed "Resident was moved from 600 hall to spend the night on 700 hall (Acute Unit) due to safety concerns on 600 hall. (Psychiatric Residential Treatment Facility- PRTF) - "Patient observation rounds" sheets dated 7/18/21- 7/19/21 FC#11 observation on 703-A - "Patient observation rounds" sheet dated 7/20/21 "Patient is on the hall for a short period of time. He is officially on hall 600." - Daily Nursing Note dated 7/19/21 revealed FC#11 "being programmed on another	V 105	V 105 Continued CPI refresher training will be completed with all direct care staff. Additional CPI training and use of de-escalation techniques has been assigned to all direct care staff. One Hour Face to Face education has been reviewed and will be completed with RNs covering processes and documentation requirements. Electronic documentation has been updated with a Red Alert notification for the nurse ensuring a provider's order has been completed. Doctors and all providers have been given access to EHR remotely and can enter orders immediately. All direct care staff received education on the Code Brown policy and how to respond appropriately to the escalation of patient behaviors. Education has been provided to House Supervisors to ensure they understand that anyone in orientation or who are job shadowing should not be counted in staffing. **Measures put in place to prevent the problem from occurring again**. HIM will audit all physicians and providers orders. HIM will communicate with CMO/ Medical Director when providers are not completing audited documentation and report findings in QAPI.	11/17/21 11/17/21 10/26/21 10/15/21 11/5/21

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V 105	Continued From page 4 unit for safety reasons, moved to 700 hall. FC#11 is programming on another unit" - Daily Nursing Note dated 7/21/21 revealed FC#11 "Patient was discharged to 700 unit" - Discharge Notification dated 7/22/21 from 600 hall to the 700 hall - Clinical therapy progress note dated 7/22/21 "Therapist was not available at the time of [FC#11] being discharged to the Acute hall on 700 last night" - Physician order sheet dated 7/22/21 revealed "discharged patient to Acute 700 hall" Interview on 10/20/2 the Chief Nursing Officer reported: - Clients would only be moved to the Acute Unit with a doctor's order. - Clients would be moved if the doctor felt the patient was "too the acute for the PRTF" - A move from the PRTF would be considered a discharge and if moved on the Acute Unit, it would be considered an admission - Parents consent would have to be given before patients can move from the PRTF to the Acute Unit - She was only aware of one patient's move from the PRTF to the Acute Unit since being employed in February 2021. - Not aware of FC#11's move at the time of this interview - The 700 hall was considered the Acute Unit Interview on 10/25/21 the Chief Executive Officer (CEO) stated: - When a client was moved from the Acute Unit to the PRTF, the discharge was completed that day before they go to the Acute Unit - "It's all doctor driven, that would be weird	V 105	V 105 Continued Direct care staff trainings will be completed to 100% of all staff working. Staff not completing trainings will not be placed on the schedule. Trainings and competencies will be maintained in the HR file and added to training tracking form which is reported out in QAPI. 100% of the Physician/ Provider restraint/ seclusion orders will be monitored for 60 days or until completion until 98% compliance is achieved for 4 consecutive weeks. Compliance will be reported monthly through QAPI, Med Exec, and Governing Board. 100% of One Hour Face to Face documentation will be monitored for completion for 60 days or until 98% compliance is achieved for 4 consecutive weeks. Compliance will be reported monthly through QAPI, Med Exec, and Governing Board. Staff not completing the required documentation will receive documentation of follow up coaching by the appropriate director. **Who will monitor the situation to ensure it will not occur again**. CEO CNO CMO Medical Director **How often the monitoring will take place** Daily V 105 Ends	11/17/21

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V 105	Continued From page 5 to move from PRTF to Acute for safety" - "I can't imagine moving a client from PRTF to Acute for safety reasons, that does not make sense" - A doctor's order required to admit or discharge to the Acute Unit - Not aware of a client being moved to the Acute Unit from the PRTF - Not aware of FC#11 staying on the Acute Unit without being discharged from the PRTF Below are examples of where the following Codes of Federal Regulations (CFR) were not followed: Review on 10/25/21 of facility Policy on Seclusion and Restraint revealed the following: - Time limitations: "Once a restraint or seclusion has been implemented the Qualified RN (Registered Nurse) shall conduct a face to face assessment. The RN shall inform the psychiatrist/physician/provider of the patient's current condition. The psychiatrist/physician/provider will decide whether or not to continue the restraint or seclusion " "The face-to-face assessment and the restraint or seclusion order must be documented in the patient's medical record. The restraint or seclusion report and the incident report shall be completed by staff involved in the emergency safety intervention before the end of the shift. This includes but is not limited to: The patient physical and psychological status The patient's behavior Least restrictive interventions used prior to the restraint/seclusion The appropriateness of the intervention measures and	V 105		

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V 105	Continued From page 6 Any complications resulting from the intervention" - Implementation of Order: "Clinical staff trained in the use of physical management must be physically present to continually assess and monitor the patient in a restraint or seclusion" "Monitored by a registered nurse and/or trained staff" "Restricted patients are continuously observed in person by trained and competent staff who has completed and maintained periodic training updates. Continuous observations are documented every 15 minutes. If staff are unable to visualize the patient, the door will be opened, in order to fully assess the patient. Direct patient care staff observations include: any signs of injury or distress, patient's behavior, hydration and nutritional needs, skin integrity, signs of exhaustion and indicators or readiness for discontinuation of the restraint or seclusion and recognize when to contact a medically trained license independent practitioner." "An RN assesses the patient in restraint or seclusion and documents the assessment 15 minutes or more frequently as warranted by the patient's condition." - Documentation for Emergency Safety Interventions: "All restraint techniques or seclusion will be documented by a registered nurse in the patient's medical record and will reflect justification, implementation and outcome of procedure (to include behavior at time of release) and shall address the failure of less restraint or seclusion. Documentation must be completed by the end of the shift on which the intervention occurs." "The Restraint or seclusion/Flow sheet must have an observation entry by the assigned	V 105		

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V 105	Continued From page 7 staff at least every 15 minutes from initiation of the restraint or seclusion and observation of the patient must be continuous. The RN assessment is completed at initiation and every 15 minutes, thereafter and includes, as appropriate to the type of restraint or seclusion the following: "Signs of any injury associated with applying restraint/seclusion" - Restraint or seclusion Guidelines: "When a patient is in the seclusion room he/she must be under CONSTANT observation of staff trained in the use of emergency safety situations. The staff members must be physically present immediately outside the seclusion room continuously assessing, monitoring, and evaluating the physical and psychological well-being of the patient in" B. Review on 10/25/21 CFR-"§483.358(d) Order for Seclusion or Restraint-If the order for restraint or seclusion is verbal, the verbal order must be received by a registered nurse or other licensed staff such as a licensed practical nurse, while the emergency safety intervention is being initiated by staff or immediately after the emergency safety situation ends. The physician or other licensed practioner permitted by the state and the facility to order restraint or seclusion must verify the verbal order in a signed form in the resident's record..." Review on 10/8/21 of client #1's record revealed: - Admission date 5/17/21 - 16 years old - Diagnoses: Disruptive Mood Dysregulation Disorder (DMDD), Conduct Disorder/Adolescent onset-type severe, Unspecified Mood Disorder, Cannabis Use Disorder and Oppositional Defiant Disorder (ODD)	V 105		

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V 105	Continued From page 8 Review on 10/19/21 of client #1's September 2021 Medication Administration Record (MAR) revealed: - Medication for chemical restraint not listed on 9/25/21 - No signature of medication being given on 9/25/21 Interview on 10/18/21 & 10/19/21 the Chief Nursing Officer (CNO) reported: - Did not see an order for 9/25/21 for client #1's chemical restraint - Nothing was signed off on the MAR for 9/25/21 for an injection for client #1 Interview on 10/21/21 the Nurse #1 reported: - Was a Registered Nurse (RN) - This was the 2nd day working on her own in the facility - Was the nurse that called for approval for the chemical restraint for client #1 - Can't remember the time she called the Nurse Practioner #1 (NP) - Administered Zyprexa and Benadryl injection - Didn't remember writing in the client record who she received approval from or the time - Did not sign the MAR for the chemical restraint given to client #1 Interview on 10/20/21 the NP #1 reported: - Was on call on 9/25/21 - Ordered medications for client #1 for the chemical restraint - Didn't remember the name of the nurse that called - Didn't document the call from the nurse	V 105		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE

V 105	Continued From page 9 C. Review on 10/25/21 of CFR§ 483.362-"Monitoring of the resident in and immediately after restraint-Clinical staff trained in the use of emergency safety interventions must be physically present, continually assessing and monitoring the physical and psychological well-being of the resident and the safe use of restraint throughout the duration of the emergency safety intervention and CFR 483-358 (f) Assessment post Seclusion or Restraint-Within 1 hour of the initiation of the emergency safety intervention a physician, or other licensed practitioner trained in the use of emergency safety interventions and permitted by the state and the facility to assess the physical and psychological well being of residents, must conduct a face-to-face assessment of the physical and psychological well being of the resident, including but not limited to - (1) The resident's physical and psychological status; (2) The resident's behavior; (3) The appropriateness of the intervention measures; and (4) Any complications resulting from the intervention" Review on 10/18/21 at 9:38 AM of video footage camera views inside the isolation room and 300 hall leading into the isolation room from the 9/25/21 incident revealed the following approximate time frames: - 11:12 PM, client #1 was in handcuffs and placed in the isolation room by a Police Officer, two other Officers in the hallway - 11:16 PM, an Officer is seen looking into the window until 11:17 PM and he holds the isolation room door shut with his foot - 11:32 PM Nurse #1 and a staff from another hall enter the isolation room with	V 105		

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	20140058	A. BUILDING: _____ B. WING _____	C 10/26/2021

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V 105	Continued From page 10 medication in hand...appeared she did not take the oral medication - 11:41 PM Nurse #1 left the isolation room... - 11:44 PM client received chemical restraint in each arm while still in handcuffs sitting on the floor, Officer inside the isolation room while staff outside the door... - 11:54 PM handcuffs removed by the Police as staff #3 arrived, client #1 attempted to attack the Police Officers, then House Supervisor arrived in the room...House Supervisor and Lead Mental Health Technician (MHT) #1 in the room with client #1 - 12:21 AM client #1 left the isolation room. Review on 10/20/21 of the "Patient Self-Debriefing Assessment sheet" for client #1 dated 9/25/21 revealed: - No information regarding the use of a chemical restraint Review on 10/25/21 of client #1's progress note dated 9/25/21 revealed: - No documentation of unsafe behaviors or physical aggression - No documentation of a physical or chemical restraint - No documentation of client being placed in the isolation room - No documentation of staff monitoring client throughout her time in the isolation room or after being returned to her hall throughout the night. Interview on 10/18/21 & 10/19/21 the CNO reported: - Should have been "constant" monitoring of client #1 by a MHT in the isolation room at all times	V 105		

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V 105	Continued From page 11 Interview on 10/20/21 the NP #1 reported: - Didn't document the call from the nurse - The nurse normally calls back to let them know if the medication "worked or not" - Didn't "recall" if the nurse called her to let her know the outcome of the medication Interview on 10/21/21 the Nurse #1 stated: - On 9/25/21 this was her second day working alone - There were two MHT staff on the 300 hall that shift - Staff #2 was "kind of scared" so she stayed out at the nurse's station - Was training Nurse #2 who was in her 2nd day of orientation - She (nurse 1) administered the chemical restraint to client #1 - Was supposed to check on clients every 15 minutes while in the isolation room - Sometimes they go in the isolation room if the client was calm and if not they check through the door and ask the client if they needed anything - Did not remember documenting her checks on client #1 on 9/25/21 while she was in the isolation room, but did check on her several times - Staff were supposed to stay with the client while in the isolation room monitoring them through the door Interview on 10/18/21 the Nurse #2 stated: - 9/25/21 was her second day of training and first day on the unit - Was training under Nurse #1 - Helped give client #1 her medication after the Police handcuffed her - Client #1 was in the isolation room for	V 105		

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V 105	Continued From page 12 about an hour, it took a long time for her to calm down - They did check on her, but the other nurse documented this Interview on 10/21/21 the Police Officer #1 stated: - Responded to an incident at the facility on 9/25/21. - Client #1 was aggressively kicking the door open located near a broken window - Told her to stop or he would put her in handcuffs - Client #1 said, "put me in cuffs" - During this time, no staff was immediately around him - There were staff in the nursing station - Then placed client #1 in handcuffs due to her continuing to kick the door - He asked staff for a place to put client #1 - A male staff (House Supervisor) came in and told him to place her in a room that had padded walls (isolation room) - The door to this room did not lock so another Officer had to stand by the door with his foot on the door to keep her from getting out as she was still continuing to kick the door. - The Officer was holding his foot on the door so she was not able to kick it open - The male staff was moving around the unit a lot, "I did not see staff stand by the door with the Officer, but the staff was just walking around" - He went back to the hallway and another Officer (Police Officer #2) arrived - One staff (staff #1) stayed at the end of the hall and talked to the clients too - "After a while, the staff came up with a plan to sedate the [client #1] - While in the isolation room client #1	V 105		

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V 105	Continued From page 13 remained in handcuffs - After client #1 received her medication, the Police Officer #2 tried to talk to her informing her they would remove the handcuffs if she remained calm - During this time,"the nurse was in and out of the isolation room," but not sure if she was checking client #1's vitals. - Once they got client #1 to stand and removed the handcuffs, client #1 assaulted one of the Officers - Client #1 pushed forward toward Police Officer #2 who was in the doorway - Police Officer #2 stood in front of another Officer to block client #1, but she pushed, hit and kicked the Officer - They got her back in the isolation room and Police Officer #2 told her to calm down but she tried to punch, kick and scratch him - Police Officer #2 pushed her back in the room - Police Officer #2 had to use "force-the spear technique" - The force was used to keep her from pushing out of the isolation room - They used the "arm bar technique" - During this time, the staff started to come to assist - The staff was around the door at the time - The nurse and two male staff were right outside the door - The staff then came into the isolation room, "but they did not intervene" Interview on 10/21/21 the Police Officer #2 stated: - Responded to the facility on 9/25/21 later as he was not on duty, but heard the call and spoke with the Police Officer #1 and could tell the situation was "hostile" and he asked him to come	V 105		

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V 105	Continued From page 14 help them out - Arrived in the facility around 11:30-11:45 PM - The clients were verbally "hostile" - An Officer on the scene told him they had someone in the "holding cell" (isolation room) who was "irate and hostile" - Went down the hall and talked to client #1 in the isolation room and she kept asking to take the handcuffs off - Told her there was a reason she was in them - Staff then brought in a shot and she was ok with the shot and asking for it - One staff (Nurse #2) said she was a new "contractor" (contract nurse) - This was her 1st or 2nd night working and said, "I don't even know what is going on" - Never saw the staff trying to control client #1 while he was present in the facility - While he was observing client #1 in the isolation room, only saw Nurse #2 come in and out, and the Officers were the ones handling client #1 - Client #1 was sitting on the floor handcuffed and no other staff members around - Then a nurse came to give client #1 a second shot - 1st shot in left arm and client #1 was "ok" - Took the handcuffs off and she walked out to the main hall - Another Officer was standing in the door and client #1 hit the Officer in his back - An Officer then tried to grab her hand and she swung at him - He then stepped in and she swung at him saying, "get the f***k off me" - Proceeded to block her hand and "put her in an arm bar" - "Not sure what staff was doing, I was too	V 105		

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V 105	Continued From page 15 busy blocking punches" - Got client #1 back in the room with "a wrist lock on her face" - Let client #1 go, she then jumped at him and kicked him twice - Told client #1 to back up, she tried to get to the door and she swung and hit him in the shoulder - Client #1 tried to swing again, then backed her against the wall "with my elbow in her sternum against the wall" - Client #1 reached with her other hand and tried to scratch and bite him - Then staff came in 30-40 seconds later, just saying client #1's name over and over - It was two males and one female staff that came in the isolation room and said they got her. - "I said finally, where the h**l y'all been" - Staff had "zero control, I have seen more control with 5th grader on 5th grader supervision" - "It was a d**n mess" - "I showed up to the clean up because they (staff) were drowning" - "Never been in the middle of a facility, jails, detention and etc. with no staff trying to do anything during that kind of situation" - One staff (staff #1) had a good rapport with the clients, the "rest were just bumps on a log" - "In my opinion, they (staff) should have a hold of her (client #1) a*s, not me to have to control this situation" - The new staff (Nurse #2) seemed "over her head" and the other staff was "completely stand off and wanted us (Police Officers) to do their job for them" Interview on 10/21/21 the Chief Medical Officer (CMO) stated:	V 105		

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V 105	Continued From page 16 - Was just made aware of the incident on 9/25/21 yesterday (10/20/21) from a colleague - Been providing services in Psychiatric treatment for 21 years - "Police should not be in a hospital, they can not come on to a unit and restrain someone, it's illegal." - Staff should have handled the situation and contacted the doctor Interview on 10/18/21 and 10/26/21 the Director of Quality Compliance and Risk Management stated: - Was on vacation during the incident that occurred on 9/25/21 - The situation "spiraled" and should not have led to the Police being called - When a client is in the isolation room, the staff were to observe the client at the window of the door - While watching the video of 9/25/21 on the 300 hall, not sure why staff were not present monitoring client #1 while in the isolation room - Clients should have constant monitoring while in the isolation room Interview on 10/25/21 the Program Coordinator stated: - He had been the trainer for Crisis Prevention Interventions (CPI) for the staff - Training was very clear that they were psychiatric hospital - Staff was to keep the clients safe and that was difficult to do when the staff "were not equipped to do so" - The nurses had been "reluctant" in the past to use their training - The staff definitely understand their role and to intervene - If a client was escalating, the doctor	V 105		

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V 105	Continued From page 17 should have been contacted regarding the client's behavior - Would not have contacted the Police as this could have been handled by staff if they had the correct amount of staff on duty D. Review on 10/25/21 of CFR§ 483.376 (f) Education and Training-) "Staff must demonstrate their competencies as specified in paragraph (a) of this section on a semiannual basis and their competencies as specified in paragraph (b) of this section on an annual basis" Review on 10/25/21 of staff #1's record revealed: - Hire date of 5/18/17 - Training in alternatives to restrictive interventions date: Expired 3/12/21 Interview on 10/25/21 the CEO stated: - She was the Administrator On Call (AOC) on call on 9/25/21 when the incident occurred on the 300 hall - The House Supervisor called her a little after 10:00 PM and told her the clients on 300 hall attacked and jumped on staff - The staff were injured - Never "Ok" with the Police being called on the unit, but things were "pretty heightened" - Called back in thirty minutes and things had been resolved - Reviewed the video with the staff afterwards to determine what could have been done differently - The staff who were involved that evening thought they did a good job during the incident - Concerned about how several staff just stood outside the nurse's station and not dealt with the verbal escalation going on - Not aware that many Police had to respond	V 105		

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V 105	Continued From page 18 - The staff did not respond to the situation as they were trained to do so - After the incident heard that staff working that evening were anxious and concerned about being harmed by the girls - Was not aware there was a new employee shadowing that evening alone with one other staff - Staff #2 had been trained in Alternatives to Restrictive Interventions by the time she would have shadowed and should have engaged in helping deescalate the situation - While client #1 was in isolation, she should have been in constant observation from the staff - The client should have been monitored after the isolation by the nurse and ongoing throughout the night This deficiency is cross referenced into: 10 A NCAC 27G .1901 Scope (V314) for a Type A1 rule violation and must be corrected within 23 days.			
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by		V109 begins **Measures put in place to correct the deficient area of practice:** Additional training and education on Governing Board Oversight and Executive Leadership has been completed by the CEO.	11/15/21

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V 109	Continued From page 19 exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10 A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record review, observation and interview the facility failed to ensure one of two audited Qualified Professionals (Chief Executive Officer (CEO)) demonstrated knowledge, skills and abilities required by the population served. The findings are: Review on 10/25/21 of the CEO's record revealed: - Hire date of 4/19/21 - Received a Master's Degree in Education	V 109	CEO, QIRM, CNO, and DCS have registered for NC DHSR MHLS: Provider training in Raleigh. Weekly mentoring and coaching with the CEO has been scheduled with a seasoned CEO from a sister facility. First mentoring session has been completed. CEO completed and reviewed the Orientation and competency checklist with CEO at sister facility. **Measures put in place to prevent the problem from occurring again**. Documentation from the weekly coaching will be forwarded to the CEO's supervisor for evaluation of duties. CEO will maintain continuing education credits (CEUs) for healthcare leadership at the equivalent of 2 CEUs per quarter. CEO will be evaluated yearly on performance indicators including knowledge of NC PRTF licensing regulations, Governing Body and Oversight of the hospital, polices procedures, and Quality Indicators and outcomes. **How often will the monitoring take place and by whom:** CEO's Supervisor Mentor CEO Weekly Monthly Yearly	11-10-21 11-13-21 11-13-21

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V 109	Continued From page 20	V 109		

- Job description/job duties revealed:

"The Chief Executive Officer (CEO) is accountable for administering, directing and coordinating through the executive team of operations of the behavioral health system. The CEO remains current with changing industry conditions, accreditation/licensing requirements, contemporary analytics and market requirements... The CEO, alongside the Board, Medical Staff leadership, champions quality patient care in support of positive clinical outcomes. CEO assumes full operational oversight of the facility. The CEO will actively facilitate strategic planning and corresponding development activities including but not limited to: budgeting, community outreach, human resource management, patient services, payer contracting, medical/psychiatric resources, regulatory preparedness and quality improvement. This position exercises prudent decision making, initiative, judgment, problem solving and self-regulation within a multitude of situations."

Below are examples the CEO did not demonstrate competency:

A. Refer to V105 example A regarding Former Client (FC#11) was moved to a different level of care without prior authorization or approval. Outlined in the citation included the following information:

-Between 7/17/21 and 7/20/21 FC#11 was programmed during the day on his assigned 600 hall. He received medical and housing during other hours including overnight observations on the 700 hall. The 700 hall was licensed for clients with the need for a higher level of care. This type of care is provided as the Acute unit. On 7/21/21, FC#11 was admitted to 700 hall.

-FC#11's record revealed no physician's

V 109	Continued From page 21 order, guardian consent for the 7/17/21-7/20/21 reassignment of FC#11 -The Chief Nursing Officer (CNO) reported the move between acute unit and PRTF (Psychiatric Residential Treatment Facility) would have been considered a discharge and would have only occurred if a physician felt the client was "too acute" for the PRTF to meet his needs. Parents consent would be required. Interview on 10/25/21, the CEO stated: - When a client moved from the PRTF Hall to the Acute Hall, the discharge was completed that day before they transfer to the Acute Unit. - "It's all doctor driven, that would be weird to move from PRTF to Acute Unit (hall) for safety." - "I can't imagine moving a client from PRTF to Acute Hall for safety reasons, that does not make sense." - A doctor's order was required to admit or discharge to the Acute Unit Unit. - Not aware of a client being moved to the Acute Hall from the PRTF - Not aware of FC #11 staying on the Acute Hall without being discharged from the PRTF Interview on 10/26/21 the Director of Quality Compliance and Risk Management stated: - Was made aware of FC#11 being moved from the PRTF to the Acute Hall without being discharged during their morning "flash meetings" - "Flash meetings" were held every morning with all department heads. During the meeting, attendees discussed what was going on across the hospital - It was reported from the court liaison there were concerns from the Special Counsel regarding FC#11's move to Acute Unit Unit - During the meeting the CEO called the	V 109		

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V 109	Continued From page 22 House Supervisor and stated to the group that the issue had been resolved - Later that day she learned there was still an issue regarding FC#11 still being on the Acute Hall and that the CEO was aware of it. - The House Supervisor told her (the Director of Quality Compliance and Risk Management) that she had contacted the CEO over the weekend because the CEO was the Administrator on Call (AOC) and she gave the "ok" for FC#11 to move to the Acute Hall for safety. - She had spoken to the Admission and Referral Manager (A&R) to get an update about the status on FC #11. - The A&R Manager stated she was having a hard time getting the guardian's consent. - The doctor was supposed to do the paperwork and he had not, therefore she could not officially discharge FC#11 from one unit to another. - "Even if you get a doctor order you can't move until you get the guardian consent." - Instructed the A&R Manager to go to the CEO for guidance on this issue - The A&R Manager went to the CEO and the CEO told her to let him stay on the Acute Hall another night. - After finding out this information, she had a conversation with the CEO about it. - "As the Risk Manager, I went to the [CEO]'s office to address it." - The CEO said "I know you don't like it and what do you want me to do, it's already done." - After that conversation, she contacted Corporate Compliance to let her know and she said she would handle it. - Their company attorney had reached out to her later in the week to check on the situation	V 109		

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	20140058	A. BUILDING: _____ B. WING _____	C 10/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVIORAL CENTER-GARNER	3200 WATERFIELD DRIVE GARNER, NC 27529

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V 109	Continued From page 23 as he was informed from the corporate office regarding the matter. - After this situation, morning "flash meetings" were then changed. - Now at the "flash meetings" each department representative presented what occurred in their department and then excused from the meeting. - She was the second or third person to present and then excused from the remainder of the "flash meeting." - Only the CNO and CEO remained throughout the entire "flash meeting." - "This is a problem" as she is over the entire hospital for compliance and risk management. - Had resigned her position and her last day will be 10/28/21 - Can not "effectively" do her job under this type of management B. Observation on 10/20/21 at 2:00 PM several clients on 300 hall had on fake eyelashes and client #1 had a nose piercing Interview on 10/20/21 a Teacher stated: - Clients showed up in her class today with fake eyelashes on and client #1 had a nose piercing (stud). - They told her the CEO allowed them to have the items. - They do not usually have those items to use. - Concerned about hygiene issues with the clients using the same glue or piercing Interview on 10/20/21 the Director of Utilization Review reported: - Clients had not been permitted to wear fake eyelashes or a nose piercing in the 8 years	V 109		

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V 109	Continued From page 24 she had worked there. - She was told the CEO allowed the clients to go into the contraband closet to get the eyelashes and the nose piercing and allowed them to wear those items. - Did not think the nose piercing and the eyelashes were appropriate for this type of setting - She thought it was "unsanitary." Interview on 10/26/21 staff #6 stated: - Noticed the clients on the 300 hall had eyelashes on and a client with a nose piercing a few weeks ago - Was told by a lead Mental Health Technician (MHT) that the CEO took some of the clients to the contraband closet to retrieve those items. - The staff were "shocked" she allowed them to do this - The clients were walking around with fake eyelashes on and a nose piercing, "All they needed to do was go to the club." - On one occasion a client was complaining about her eyes hurting her from wearing the eyelashes. - Clients shared the eyelashes and she was not sure what was used to apply the eyelashes. Interview on 10/26/21 the Director of Quality Compliance and Risk Management stated: - Was told by a staff that the CEO took the clients to the "bin" room to get some items and they were allowed to get eyelashes - Was told they were using "gorilla snot" hair gel to apply the eyelashes - Was concerned about this and went to the CNO to ask about the safety of using hair gel around the eye area - The CNO told her the hair gel would not	V 109		

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V 109	Continued From page 25 be near their eyes. - Still very concerned as the eyelashes were attached to the eye lid and the hair gel would run into their eyes - Had never known in her three years of employment of the clients being allowed to have those type of items - Very concerned that client #1 was allowed to put a nose piercing in for safety reason - This should have been assessed by the doctor to determine the level of safety and observation as to what should be allowed with these items. Interview on 10/21/21 the Chief Medical Officer (CMO) stated: - Was not aware of clients having fake eyelashes or nose piercing - "This is concerning, as who let it happened" - Would not advise this to the clients unless they were assessed to do so - "This is a hospital." - Each client should have been assessed individually by the physician, nurse and therapist before allowing the clients to have those items. - This should not have been a "blanket decision." Interview on 10/25/21 the CEO stated: - They held a "spa day" a few days ago. - Had a staff to go buy some face mask and foot cream to reward the girls on hall 300 - Not aware of any client having a nose piercing - Was aware they had eyelashes - Assumed that was from their spa day - Was told they were using "gorilla spit" hair gel to apply them - The clients have hair gel in their hygiene	V 109		

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V 109	Continued From page 26 bins - Didn't think this was a problem for them to have the eyelashes C. Review on 10/20/21 of the North Carolina Incident Response Improvement System for Client #1 revealed: - Incident occurred on 9/25/21 - Provider summary: "Restrictive Intervention: Provider 09/28/2021 Patient was agitated, uncooperative, belligerent, irritable, and wanted to fight/ destroy property per the restraint documentation. Patient displayed violent self-destructive behavior, violent behavior towards others, staff assault, patient assault. Patient was restrained to prevent causing further harm to herself or others and to prevent her from destroying more property. Patient was banging on doors and windows. Police were called to help get control of patient. Patient fought the police and refused to stop banging on doors and windows. Medication was given to help calm patient, ineffective at first. Per documentation patient was administered a chemical restraint." Review on 10/20/21 of the Facility Incident Report for client #1 revealed: - Alleged incident date: 9/25/21 - "Staff were unable to control the situation, so AOC [CEO] was called to permit police back up. Police were called to back up staff because the staff were unable to control residents' unsafe behavior. During police presences, patient [client #1], was placed in police handcuff because she refused to stop kicking the unit door to go out of the hall. Patient told police "I will kick until police to take me to jail". After police prompted her several time and did not stop, she was placed on handcuff and send to the quiet room. After police released patient, she refused to stay in the quiet	V 109		

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V 109	Continued From page 27 room when she asked to stay. When police were preventing her from going out, she started kicking and punching police. Resident wrestle with police until they were able to hold her. During the process, writer police to allow him to continue talking to patient to calm down." - Report completed by House Supervisor Review on 10/20/21 at 10:30 AM of video footage from the 9/25/21 incident on the 300 hall revealed the time frame of incident from 9:15 PM until 12:14 AM when client #1 was removed from the isolation room and returned to her room. Interview on 10/18/21 the House Supervisor reported: - A code purple was called on hall 300 - They couldn't get control of the hall - Called the Administrator On Call (AOC) - The AOC for 9/25/21 was the CEO - Informed CEO that all resources had been exhausted - The CEO stated she was okay with him calling the Police Interview on 10/25/21 the CEO stated: - She was the AOC on call on 9/25/21 when the incident occurred on the 300 hall - The House Supervisor called her a little after 10:00 PM and told her the girls unit was attacking staff and jumping on staff - The clients were attacking staff and staff was injured - The House Supervisor stated he had already called the Police when he called her - The House Supervisor had used the "code brown" which is when the staff is giving the authority to call the Police during a riot. - The staff had utilized all other options prior to calling the Police	V 109		

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V 109	Continued From page 28 - Never "Ok" with the Police being called on the hall, but things were "pretty heightened" - Called back in thirty minutes and things had been resolved - Did not review the video of the incident on 9/25/21 until 10/4/21 Interview on 10/26/21 the Director of Quality Compliance and Risk Management stated: - Was on vacation during the incident that occurred on 9/25/21 - Had since reviewed the video and felt the situation could have been handled differently from the beginning of the behaviors starting. - The physical aggression was from client #1 and no other clients, not a "riot" - The CEO told her she was called by the House Supervisor that evening saying there was not enough men around to handle the situation with client #1. - The CEO then told the House Supervisor to call the Police to help control the unit - This type of peer on peer conflict is"typical" behavior in a PRTF. - This was a "code purple," which is for a "combative situation." - Had been employed for three years and never heard of a "code brown" being called. - The Police should not have been called in this situation. Interview on 10/21/21 the CMO stated: - Was not aware of the situation that occurred on 9/25/21 until yesterday (10/20/21) when a colleague informed him of it - The CEO had not informed him of the incident. - From what he was told, this was a behavior of one client. - Police should never be called to a	V 109		

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V 109	Continued From page 29 hospital, the doctor should be contacted. - "Cops should not be at a hospital, they can not come on the unit and restrain someone because it's illegal." - "I have been doing this for 21 years, if therapy does not work, you don't call the Police, that does not work." - "How can you run a hospital when it's a revolving door of staff." - Had been employed for three years at the hospital and been through four CEOs - This CEO started six months ago and "thinks she knows everything." - Weeks go by and he does not hear anything going on in the PRTF. - The CEO had been making medical decisions since she started that she is not qualified to make and not telling him what she was doing. - She would do stuff "behind closed doors" and then come out and say she didn't do it - The CEO is pushing for admissions when they can not handle it, "it's a money game" - The CEO would hire different physicians and not even let him know - There have been lots of resignations since she started from really good staff - Sent the President of the company an email outlining everything that had been going on since she was hired. - Had given his resignation and his last day was 10/22/21 This deficiency is cross referenced into: 10A NCAC 27G .1901 Scope (V314) for a Type A1 rule violation and must be corrected within 23 days.	V 109		

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			APPROPRIATE DEFICIENCY)	
V 113	Continued From page 30	V 113	V 113 Begins	
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information	V 113	**Measures that will be put in place to correct the deficient area of practice:** Process for communication of any patient infection or medical concerns is now being completed in the EHR. Once this form is initiated by the nurse, the form with patient concerns is routed to the provider for review. 11/17/21 Education has been completed with the nursing staff regarding appropriate entry of orders. Education has been completed with the physicians/ providers regarding appropriate entry of orders. A standardized process and forms for completion by the PRTF provider and consulting physician/ provider is being developed to improve communication of consulting care provided to include instructions for patient care follow up on return to PRTF. 11/17/21 Education on the standardized Consultation process will be completed with nursing and physician/ provider staff. 11/17/21 **Measures that will be put in place to prevent the problem from occurring again:** Infection/ medical concerns documentation and reporting will be reviewed weekly by the Infection Control Nurse. IC RN will report to the CNO any report of concerns for follow up on by the physician/ provider within 24 hours. 11/17/21	

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V 113	Continued From page 31 relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143. This Rule is not met as evidenced by: Based on record review and interview the facility failed to maintain documentation of services provided for one of two audited Former Clients (FC#10). The findings are: Review on 10/18/21 of FC#10's record revealed: - Admitted 4/21/21 and discharged 9/29/21 - Diagnoses of Disruptive Mood Dysregulation Disorder, Major Depressive Disorder, Trauma & Post Traumatic Stress Disorder - Age: 14 Review on 10/20/21 of the Daily Nursing Notes for FC#10 revealed: - "7/16/21: complained of abdominal pain ...Tylenol given" - "7/17/21: complained of burning sensation during urination ...urine frequency. Medical consult placed to follow up ...call to guardian no answer" - "7/21/21: transported to primary physician's office for PCR (polymerase chain reaction) testing ...Tylenol given prior to departure for headache" Review on 10/18/21 of the facility's consultation/follow up examination form dated 7/17/21 for FC#10 revealed:	V 113	V 113 Continued Physician/ provider not addressing infection/ medical concerns timely will receive follow up with the CMO or Medical Director. Monitoring of Consultation Documentation upon return of Consultation Appointments for completeness of patient follow up care. Nursing and physician/ provider trainings will be completed 100% of all staff working. Staff not completing trainings will not be placed on the schedule. **Who will monitor the situation to ensure it will not occur again:** CEO CNO Infection Control CMO Medical Director **How often the monitoring will take place:** Daily/ Weekly/ Monthly Monitoring as indicated. V113 Ends	11/17/21

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V 113	Continued From page 32 - Reason for Consultation: possible Herpes and UTI (Urinary Tract Infection) - "Send pt (patient) to get PCR testing for suspected genital herpes recurrent rash and itchy areas" - Signed by Physician Assistant (PA) - No documentation of the follow up visit to the primary physician's office Interview on 10/25/21 the Chief Nursing Officer (CNO) reported: - The staff that transported the client to the appointments, would bring the documentation back from the outside provider and give to the Registered Nurse (RN) - The RNs ensured the medical information was placed in the clients' records - She would follow up to see if any documentation was received from FC#10's July 2021 primary care visit The documentation was not received by the exit survey date of 10/26/21 Interview on 10/21/21 the PA reported: - He did not receive any information based on the 7/17/21 referral - If FC#10 was seen by the outside provider, the information should have been placed in FC#10's record Interview on 10/21/21 the Chief Executive Officer reported: - Staff that transported clients to appointments, left with a packet to be completed by the outside provider - Staff returned to the facility with the completed packet and gave it to the nurses - The nurses ensured the medical information was placed in the clients' records	V 113		

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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; (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:	V 118	V 118 Begins **Measures that will be put in place to correct the deficient area of practice:** Process for communication of any patient infection or medical concerns is now being completed in the EHR. Once this form is initiated by the nurse, the form with patient concerns is routed to the provider for review. Education has been completed with the nursing staff regarding appropriate entry of orders. Education has been completed with the physicians/ providers regarding appropriate entry of orders. A standardized process and forms for completion by the PRTF provider and consulting physician/ provider is being developed to improve communication of consulting care provided to include instructions for patient care follow up on return to PRTF. Education on the standardized Consultation process will be completed with nursing and physician/ provider staff. Doctors and all providers have been given access to the EHR remotely and can enter orders immediately. RNs and Therapists will be trained on ensuring physicians are ordering all discharges and transfers to other levels of care.	10/26/21 11/17/21

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V 118	Continued From page 34 Based on record review and interview the facility failed to ensure medications were administered on the written order of a physician for one of one current client (#1) and one of one former client (FC#10) audited for medications. In addition, one of two nurses (#1) failed to demonstrate competency. The findings are: A. The following are examples of physician orders not being followed: Review on 10/18/21 of FC#10's record revealed: - Admitted 4/21/21 and discharged 9/29/21 - 14 years old - Diagnoses of Disruptive Mood Dysregulation Disorder, Major Depressive Disorder, Trauma & Post Traumatic Stress Disorder Review on 10/18/21 of the facility's consultation/follow up examination form dated 7/17/21 for FC#10 revealed: - "Reason for Consultation: possible Herpes and UTI (Urinary Tract Infection)" - "History of Present illness: recurred ongoing rash in the pelvic area. Rash itchy. Has sexual history consisted with unprotected intercourse. Patient exhibiting Dysuria and increase urinary frequency and back pain" - "Assessment/diagnosis: Herpes, UTI and Dysuria" - "Plan/Orders: Valacyclovir 500 milligrams (mg) by mouth (PO) daily (herpes virus), Pyridium 200mg three times daily for 2 days" (UTI) - Signed by Physician Assistant (PA) Review on 10/20/21 of the Daily Nursing Notes for FC#10 revealed: - "7/16/21: complained of abdominal pain ...Tylenol given"	V 118	V 118 Continued **Measures that will be put in place to prevent the problem from occurring again:** HIM will audit all physicians and provider orders. HIM will communicate with CMO/ Medical Director when providers are not completing audited documentation and report findings in QAPI. Infection/ medical concerns documentation and reporting will be reviewed weekly by the Infection Control Nurse. IC RN will report to the CNO any report of concerns for follow up on by the physician/ provider within 24 hours. Physician/ provider not addressing infection/ medical concerns timely will receive follow up with the CMO or Medical Director. Monitoring of Consultation Documentation upon return of Consultation Appointments for completeness of patient follow up care. Nursing and physician/ provider trainings will be completed 100% of all staff working. Staff not completing trainings will not be placed on the schedule. **Who will monitor the situation to ensure it will not occur again:** CEO CNO Infection Control CMO Medical Director	

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V 118	Continued From page 35 - "7/17/21: complained of burning sensation during urination ...urine frequency. Medical consult placed to follow up ...call to guardian no answer" - "7/18/21: complain Dysuria, frequent urination and rash ...fluids encouraged ...left message for (Department of Social Services) DSS guardian and her supervisor for consent to be signed" - "7/19/21: consent for PCR (polymerase chain reaction) testing signed by DSS guardian" - "7/21/21: transported to primary physician's office for PCR testing ...Tylenol given prior to departure for headache" Review on 10/21/21 of a faxed medical summary from the primary physician's office to the Division of Health Service Regulation for FC#10 revealed: - "Visit date: 7/22/21" - "Chief complaint: STD (sexually transmitted disease) screen...concern about vaginal bumps, intermittent dysuria and vaginal irritation for past two weeks" - "Plan: will obtain Vaginitis panel, HSV (Herpes Simplex Virus) swab, no evidence of 'red bumps' patient complained about and no open sores" - "Visit date: 8/3/21" - "Assessment: Bacterial Vaginitis" - "lab: no evidence of Herpes" - "Plan -medications: Metronidazole 500mg every 12 hours for 7 days (bacterial infections of the vagina)" - "Follow up as needed" Review on 10/20/21 of the facility's physician's order sheet dated 8/6/21 for FC#10 revealed: - Cultarelle PO twice a day (Probiotic prevent growth of harmful bacteria in the stomach & intestine)	V 118	**How often the monitoring will take place:** Daily/ Weekly/ Monthly Monitoring as indicated. V 118 Ends	

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V 118	Continued From page 36 - Metronidazole 500mg twice a day for 7 days Review on 10/20/21 of the August 2021 MAR for FC#10 revealed: - Metronidazole was administered 8/7/21 - 8/13/21 Review 10/22/21 of the facility's pharmacy's "All Transaction Activity Detail Report" from 7/17/21 - 7/31/21 for antibiotics for FC#10 revealed: - no antibiotics were administered between 7/17/21-7/31/21 Interview on 10/25/21 the CNO (Chief Nursing Officer) verified - No antibiotics were administered between 7/17/21-7/31/21 Interview on 10/19/21 FC#10 reported: - Was tested for STDs by an outside agency - 2 staff took her to the appointment - She was negative for STDs - She was only treated during her stay at the facility with Tylenol or an over the counter Probiotic for yeast - She had recurring UTIs during her stay at the facility - She continually asked for medication for the pain Interview on 10/19/21 & 10/20/21 the CNO reported: - On 7/17/21 the PA listed medications: Valacyclovir & Pyridium on the consultation form & not on the facility's physician's order form - Medication orders had to be listed on the physician's order form in order for the nurses to send to the pharmacy	V 118		

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V 118	Continued From page 37 - Thought it was an oversight by the PA that he listed the medications on the consult form and not the physician's order form - There was no documentation an antibiotic was given until 8/7/21 - Medications listed from outside providers could not be filled until the facility's physicians reviewed the medications - The facility's physicians would then write an order to be filled by the physicians pharmacy - She was not sure why the facility's Nurse Practitioner did not write the physicians order until 8/6/21 - FC#10 probably felt some discomfort and pain - The nurses were responsible for ensuring the physicians were notified if an outside providers wrote physician orders - The medication system had improved since the facility went electronic as of 8/18/21 Interview on 10/21/21 the PA reported: - Recalled FC#10 - He always documented concerns on the consultation form and immediately on the facility's physician order form - Either the nurse faxed the 7/17/21 physician's order for the antibiotic and did not put the documentation back in FC#10's record or the information was not faxed at all to the pharmacy - It was a system failure if FC#10 did not receive the antibiotic prescribed 7/17/21 B. Example no physician's order for injections given for behaviors Review on 10/8/21 of Client #1's record revealed: - Admission date 5/17/21 - 16 years old	V 118		

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V 118	Continued From page 38 - Diagnoses: Disruptive Mood Dysregulation Disorder, Conduct Disorder/Adolescent onset-type severe, Unspecified Mood Disorder, Cannabis Use Disorder and Oppositional Defiant Disorder Review of facility video on 10/7/21 of the 9/25/21 incident with Client #1 revealed: - 11:44 PM injection was given in the left arm (by Nurse #1) - 11:45 PM injection was given in the right arm (by Nurse #1) Review on 10/19/21 of Client #1's September 2021's MAR revealed: - Medication for the injection given was not listed on 9/25/21 - No signature of medication being given Interview on 10/12/21 Client #1 reported: - Received an injection on 9/25/21 because "I wouldn't calm down" Interview on 10/18/21 & 10/19/21 the CNO reported: - Did not see an order on 9/25/21 for client #1's injection for her behaviors - Client #1 would have been given a Zyprexa and Benadryl injection for behaviors - Nothing was signed off on the MAR for 9/25/21 for an injection - Didn't know why there was nothing documented Interview on 10/21/21 Nurse #1 reported: - She was a Registered Nurse (RN) - The incident on 9/25/21 was her 2nd day working on her own in the facility - Worked 7:00 PM - 7:00 AM - She called the Nurse Practitioner for	V 118		

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V 118	Continued From page 39 authorization for client #1's injection on 9/25/21 - She gave client #1 a Zyprexa and Benadryl injection for behaviors - Did not sign the MAR for the injections given to client # 1 Due to the failure to accurately document medication administration it could not be determined if client received medication as ordered by the physician. Review on 10/26/21 of the facility's Plan of Protection dated 10/26/21 and signed by the CEO (Chief Executive Officer) revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? Verification that all providers have access /remote access to the Electronic Health Record will be completed by end of the day today, 10/26/21. Completion of CPOE (Computerized Physician Order Entry) Training and how to enter orders electronically will be completed by end of the day today, 10/26/21. All providers will receive education on correct documentation of orders, including verification of telephone orders by end of the day today, 10/26/21. Nursing staff will receive education on correct documentation and verification of provider orders by end of the day today, 10/26/21, or prior to their next scheduled shift. A pop-up warning has been added to initiation of the Restraint/Seclusion documentation in the electronic health record instructing the RN to obtain an order from the provider. -Describe your plans to make sure the above happens. 1. HIM (Health Information Management) will audit all physicians and provider orders. HIM	V 118		

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V 118	Continued From page 40 will communicate with CMO/Medical Director when providers are not completing audited documention and report findings in QAPI (Quality Assurance Performance Improvement). 2. Direct care staff trainings will be completed to 100% of all staff working. Staff not completing trainings will not be placed on the schedule. Trainings and competencies will be maintained in the HR (Human Resources) file and added to training tracking form which is reported out in QAPI. 3 Physicians/providers not completing trainings will not be placed on the schedule." Clients ranged in ages from 14-16 with diagnoses which included Disruptive Mood Dysregulation Disorder, Major Depressive Disorder, Conduct Disorder, Post Traumatic Stress Disorder, Oppositional Defiant Disorder, Unspecified Mood Disorder and Cannabis Use Disorder. On 7/17/21, FC#10 informed the facility's PA she had an itchy rash in the pelvic area, Dysuria and back pain. The PA prescribed Pyridium and Valacyclovir on 7/17/21. FC#10 was seen by an outside provider on 8/3/21 and diagnosed with Bacterial Vaginitis. She was prescribed an antibiotic during the 8/3/21 visit. FC#10 did not receive any medications for the symptoms she had until 8/7/21. FC#10 complained of pain but was only given a Tylenol. The CNO said the facility's PA wrote the 7/17/21 prescription on the facility's consultation form and not on the facility's physician's order form. The nurses followed orders listed on the physician's order form. The PA said the medication prescriptions were written on both forms and a system failure prevented FC#10 from getting the prescribed medications she needed to relieve her symptoms. Client #1 received a Zyprexa and Benadryl injection on 9/25/21 for behaviors. There was no	V 118		

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V 118	Continued From page 41 documentation of staff signatures on the September 2021 MAR for the injections that was given to client #1. The RN said it was her second day working in the facility on her own. The RN secured the order from the doctor for the injections but failed to document it on the MAR. The CNO could not find a physician's order for either injection. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $3,000 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 118		
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.	V 314	V 314 Begins **Measures that will be put in place to correct the deficient area of practice:** Education on the discharge process for PRTF is being completed with all direct care staff. Education on the discharge process for PRTF is being completed with all physicians/ providers. RNs and therapists have been trained on ensuring physicians are ordering all discharges and transfers to other levels of care. Restraint/ seclusion policies and processes are being reviewed with staff and physicians/ providers. CPI training is being completed with all direct care staff every six months.	11/17/21 11/17/21 11/17/21

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V 314	Continued From page 42 (e) The PRTF shall serve children or adolescents for whom removal from home or a community-based residential setting is essential to facilitate treatment. (f) The PRTF shall coordinate with other individuals and agencies within the child or adolescent's catchment area. (g) The PRTF shall be accredited through one of the following; Joint Commission on Accreditation of Healthcare Organizations; the Commission on Accreditation of Rehabilitation Facilities; the 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 ensure a structured living environment with specialized interventions on a 24-hour basis affecting one of ten audited current clients (#1) and failed to ensure therapeutic interventions addressed functional deficits associated with the child or adolescent's diagnoses affecting six of ten audited current clients (#1, #4, #6, #7, #8 and #9). In addition, the facility failed to coordinate services with other individuals and agencies affecting one of ten audited current clients (#4) and one of two former clients (FC#10). The findings are:	V 314	V 314 Continues Education of therapy documentation requirements is being completed with all clinical therapists. Additional CPI training and use of de-escalation techniques has been assigned to all direct care staff. One Hour Face to Face education has been reviewed and will be completed with RNs covering processes and documentation requirements. Electronic documentation has been updated with a Red Alert notification for the nurse ensuring a provider's order has been completed. All direct care staff have been trained on expectations and responsibilities for their position. Prior to being admitted to program, clear expectations for all items that would be considered contraband including piercings will be clearly explained to families, patients with piercings in currently will be assessed by physicians for safety. All direct care staff has been trained on all aspects of verbal de-escalation, milieu management, leadership, roles, responding and responsibilities in codes. All direct care staff have been trained on all aspects of seclusion and restraint to include observations during and after interventions.	11/17/21

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V 314	Continued From page 43 A. Cross Reference 10A NCAC 27G .0201 GOVERNING BODY POLICIES (V105) Based on record review and interview the facility failed to follow its discharge policy and failed to implement written standards that assured operation and programmatic performance meeting applicable standards of practice for restraint and seclusion orders along with monitoring of the client in and immediately after restraint, assessment post seclusion or restraint and meeting training requirements for a staff involved in a seclusion and restraint incident B. Cross Reference 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (V109). Based on record review, observation and interview the facility failed to ensure one of two audited Qualified Professionals (Chief Executive Officer (CEO)) demonstrated knowledge, skills and abilities required by the population served. C. Cross Reference 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (V536) Based on interview and record review the facility failed to ensure five of five staff (#1, #2, Nurse #1, Nurse #2 and House Supervisor) working during an incident demonstrated competency in alternatives to restrictive interventions and one of five staff (#1) training in alternatives to restrictive interventions was expired. D. Cross Reference 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (V537) Based on interview and record review the facility failed to ensure five of five staff (#1, #2, Nurse	V 314	V 314 Continued **Measures that will be put in place to prevent the problem from occurring again:** Individual clinical therapy documentation will be completed and in the medical record no later than 48 hours of completion. 100% of clinical individual therapy documentation will be reviewed for the next 60 days or until 98% compliance is achieved for 4 consecutive weeks. Therapists not completing the required documentation will receive documented follow up with the DCS or CEO. HIM will audit all physicians and providers orders. HIM will communicate with CMO/ Medical Director when providers are not completing audited documentation and report findings in QAPI. Trainings and competencies will be maintained in the HR file and added to training tracking form which is reported out in QAPI. Physician's/ provider's order will be required for patients to maintain current piercings. Physician/ providers orders for PRTF will be monitored for completion 100% for all PRTF admissions. Physicians/ providers not completing orders for patient piercings will receive follow up by the CMO or Medical Director. 100% of the Physician/ Provider restraint/ seclusion orders will be monitored for 60 days or until completion until 98% compliance is achieved for 4 consecutive weeks. Compliance will be reported monthly through QAPI, Med Exec, and Governing Board.	

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V 314	Continued From page 44 #1, Nurse #2 and House Supervisor) working during an incident demonstrated competency in Seclusion, Physical Restraint and Isolation Time-Out and one of five staff (#1) training in Seclusion, Physical Restraint and Isolation Time-Out had expired. E. Examples no individual therapy services provided: Review on 10/8/21 of client #1's record revealed: - Admitted 5/17/21 - Age: 16 - Diagnoses: Disruptive Mood Dysregulation Disorder (DMDD), Conduct Disorder/adolescent onset-type severe, Unspecified Mood Disorder, Oppositional Defiant Disorder (ODD) and Cannabis Use Disorder - Treatment Plan dated 9/7/21 listed individual therapy once per week - Individual therapy completed on 9/9/21 & 9/14/21. No other individual therapy sessions noted Review on 10/7/21 of client #4's record revealed: - Admitted: 9/1/21 - Age: 14 - Diagnosis: Major Depression - Treatment Plan dated 7/31/21 listed individual therapy once per week - No Individual Therapy notes for October 2021 Review on 10/8/21 of client #6's record revealed: - Admitted 4/15/21 - Age: 13 - Diagnoses: DMDD, Post-traumatic Stress Disorder (PTSD) and Child Sexual Abuse Confirmed/Initial Encounter - Treatment Plan dated 4/9/21 listed	V 314	V 314 Continued 100% of One Hour Face to Face documentation will be monitored for completion for 60 days or until 98% compliance is achieved for 4 consecutive weeks. Compliance will be reported monthly through QAPI, Med Exec, and Governing Board. Staff not completing the required documentation will receive documentation of follow up coaching by the appropriate director. **Who will be monitoring the situation to ensure it will not occur again:** CEO CNO CMO Medical Director **How often the monitoring will take place:** Weekly/ Monthly V 314 Ends	

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V 314	Continued From page 45 individual therapy once a week - Individual therapy completed on 9/8/21 & 9/20/21 Review on 10/8/21 of client #7's record revealed: - Admitted 8/3/21 - Age: 17 - Diagnoses: ODD and Attention Deficit/Hyperactivity Disorder (ADHD) - Treatment plan dated 9/22/21 listed weekly individual therapy - Therapy took place on 9/10/21, 9/20/21 & 9/29/21 Review on 10/8/21 of client #8's record revealed: - Admitted 7/19/21 - Age: 12 - Diagnoses: PTSD, Unspecified Schizophrenia, Generalized Anxiety Disorder and ADHD - Treatment plan dated 6/7/21 listed weekly individual therapy - Individual therapy completed on 9/14/21 Review on 10/7/21 of client #9's record revealed: - Admitted: 9/2/21 - Age: 15 - Diagnosis: DMDD - Treatment Plan dated 9/13/21 listed therapy once a week - Notes for Recreational and Group therapy noted. No documentation for individual therapy noted between September-October 7, 2021. Interview on 10/12/21 the Acting Director of Clinical Services reported: - Had been promoted in June or July 2021 - Was the only person in her department until 8/23/21, when a new therapist started	V 314		

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V 314	Continued From page 46 - Conducted group sessions on the hall and some individual therapy as she could - Would not be surprised if some clients had not had individual therapy sessions - A third therapist had been hired but she was not sure of the start date Interview on 10/25/21 the CEO reported: - The (Psychiatric Residential Treatment Facility) PRTF had therapists and clients received individual therapy weekly - She looked in the clients' charts and reviewed notes, therefore she thought clients received individual therapy - A new therapist was hired to start 11/1/21 F. Example of the facility's failure to coordinate with external agencies for client #4: Review on 10/20/21 of email exchanges dated between 08/10/21-8/30/21 that involved client #4's therapist at Sister Facility A, Clinical Care Coordinator (CCC) at Sister Facility A, Utilization Review Director (URD) at Sister Facility A, PRTF Coordinator for this location, Licensed Clinical Reviewer (LCC) at Local Management Entity/Managed Care Organization (LME/MCO) - 8/10/21-8/17/21 correspondences reflect processes to assure paperwork was completed and billing/authorization completed - 8/27/21 exchanges between the PRTF Coordinator at 11:32 AM to CCC and URD indicated LME/MCO requested an updated Discharge/Transition form. A message had been left about the necessity for lateral transfers and/or if that means a completely new treatment team meeting would have to be scheduled to complete. MCO requested documents by 3:00 pm. "...so I hope its an easy fix, but wanted to give you a	V 314		

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heads up on where we are currently with the authorization request."

- 8/30/21 email correspondences

at 9:58 AM URD responded: "Can you call [MCO] and let them know this patient will not be moving until tomorrow, you put a start date of 8/26 so they will not cover her here today? Thank you."

at 3:08 PM, PRTF Coordinator responded: "I will call [MCO] regarding this auth (authorization), I am also going to ask for discharge delay - CEO (Chief Executive Officer) wants the girls to admit on Wednesday 09012021."

at 3:26 PM CCC responded: "I just wanted to put everyone on the same thread. As I understand it, [client #4] is not currently covered for today unless [MCO] is able to make the adjustments. She cannot remain here past tomorrow because Dad in unavailable the rest of the week to transport her, she is not authorized to stay here any longer, and she is not stable to return home until she can admit. The team here is prepared for her to discharge tomorrow, as that is what we have planned for a few weeks now."

at 3:31 PM PRTF Coordinator responded: "ON phone with [MCO], asked to have our authorization begin on 09012021 and to extend her authorization for today and tomorrow. She will speak with supervisor and call me back before 5p."

at 3:37 PM Client #4's therapist responded: "I know that her Father has taken off of work for transportation tomorrow, and he has had it planned for some time, whereas he is unable to transport any other day. As well, her father has appointments set up for tomorrow after her discharge to take her to have her second shot for the Covid vaccine. I know from talking to him, he was very adamant about having everything

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scheduled before hand, and I don't think he would be willing to change the plans considering he has additional things scheduled for the resident. Is there any way we can keep this for tomorrow? I do believe the father would be highly upset, as he has been adamant to have things planned and not changed so that he is able to see his daughter and complete her vaccine."

at 3:48 PM Client #4's therapist responded: "I had just tried to reach out to the father and was not able to get in contact with him. I have no way of getting in contact with him before the end of this day to stop him from showing up tomorrow. He lives roughly 3 hours away and has plans to show up at our facility around 8am tomorrow morning. I have no way of putting him on halt, and the resident is not safe to remain home for a full day before admittance as there is elopement risks in the home environment."

at 4:22 PM MCO Licensed Clinical Reviewer responded: "I spoke with [PRTF Coordinator] & have adjusted both authorizations. [Sister Facility A] is now authorized through today, 8/30/21. SBH-Raleigh's (Strategic Behavioral Health-Gamer) authorization has been adjusted to 8/31/21- 10/29/21. May all go well with the transportation plan for tomorrow..."

at 4:27 PM, the Clinical Care Coordinator at Sister Facility A responded: "So does this mean we can move forward with the original plan for tomorrow?"

at 9:04 PM PRTF Coordinator responded: "Yes, I will work with CEO to make tomorrow work."

Review on 10/20/21 of email exchanges dated 8/30/21 between client #4's parent and client #4's therapist at Sister Facility A revealed:

- "I just wanted to reach out. I heard what

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happened and I am terribly sorry that happened to you. I hope you know that I had gone through everything I could to ensure they would allow you today before I relayed the information to you. I had even been reaching out as late as 9pm last night, and again to confirm that you were on the way this morning around 7:30 with them. I'm not sure where things had changed, as I never received any communication otherwise. I just wanted to reach out and apologize that you had to go through that difficult transition again. I had done everything I could to prevent it, and feel terrible that it had happened to you all, who have been soo supportive throughout this entire time. Thank you for everything you have done."

Interview on 10/15/21 client #4's father reported:

- On 8/30/21 arrangements had been made for him to transport client #4 from Sister Facility A to Strategic Behavioral Center-Garner.
- His family traveled from their home (estimated 2 1/2 hours) to Sister Facility A to pick up client #4. The family transported client #4 from the location of Sister Facility A to the Strategic Behavioral Center-Garner (estimated 2 hours). Upon arrival, he was told by the CEO, she was "not due to be admitted until 9/1/21." Initially, he was told by the CEO to take client #4 to his residence (1 hour away from the Strategic Behavioral Center-Garner) and return to the facility on 9/1/21.
- "I said we can't take care of her and sleep at night... My daughter was getting a little anxious, in the lobby waiting. I said I could go to [psychiatric hospital nearby] and have her IVC (involuntary committed). She (CEO) said let me think about it and fix it."
- The CEO arranged with Sister Facility A to re-admit client #4 for one night. Sister Facility A and this location would have a meeting point to

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transfer client #4 back to the Strategic Behavioral Center-Garner on 9/1/21.

- On 8/30/21, he had to drive client #4 back to the Sister Facility A location (estimated 2 hours) before he returned to his home (estimated 2 1/2 hours).

Due to extended leave status, the PRTF Coordinator was not available for interview during this survey.

Interview on 10/18/21 the LME/MCO Care Coordinator reported:

- Client #4 was recommended to be laterally moved to the Strategic Behavioral Center-Garner due to a lack of progress at the Sister Facility A.
- The Care Review Team (consisting of staff from the LME/MCO and transferring agencies) approved the transfers.
- The transfer was approved in the LME/MCO data base on 8/27/21.
- The day it was approved, a bed should have been available.
- The data base generates the approval/authorization when the bed is available.
- Client was not approved to be in the community and could not return home with family when the facility turned her away.

Interview on 10/19/21 the CEO reported:

- The transfer to the Strategic Behavioral Center-Garner facility was voluntary.
- PRTF admissions are scheduled as they are voluntary admissions and based on authorization and bed availability.
- They were looking to admit her from Sister Facility A.
- They didn't plan to admit her until the next day. They were going to "meet the Sister

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Facility A staff halfway and exchange patients as they had a patient that they were swapping."

- She and the Director of Quality Compliance and Risk Management met with client #4's father and with the client.
- Client #4's father was out that day taking client #4 to appointments and decided to bring her to the facility.
- The transfer was coordinated with the Sister Facility A's CEO and through their PRTF Coordinators.
- The facility did not have the staffing ratio's to accommodate her.
- Sister Facility A offered to take her back for the night.
- The facility offered to pay for them to stay in a hotel for the night and accept client #4 the next day.
- The PRTF Coordinator notifies facility staff of incoming admissions/transfers by email. She was not aware of the Coordinator sending out an email that day regarding the pending admission.
- PRTF Coordinators work with nursing to be sure they have adequate ratios.

Interview on 10/19/21 the facility's Court Liaison staff reported:

- Employed 2 years as of 10/30/21
- Incoming admissions are written on the board in the admissions office and an email is sent out to departmental staff notifying staff of the incoming admission.
- She had an email notification on 9/1/21 stating that client #4 would be arriving between 12:00 PM-12:30 PM and her guardian was transporting her and signing documents.

Interview on 10/20/21 client #4's therapist at Sister Facility A reported:

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V 314	Continued From page 52 - To his knowledge, client #4 should have been transferred without any issues on 8/30/21. - Per the email exchanges prior to 8/30/21, all matters had been resolved and the transfer was set for 8/30/21. Interview on 10/26/21 the Director of Quality Compliance and Risk Management reported: - She joined the meeting between the CEO, client #4, and client #4's father per request of the CEO. - Client #4's father communicated to the Director of Quality Compliance and Risk Management that he did not want to be left alone with the CEO, he did not trust her and felt threatened by her. - Sister Facility A staff and client #4's Care Coordinator told him that client #4 was to be admitted that day - The CEO told them they did not have a bed and that she would have to reach out to Sister Facility A, to ascertain if they had a bed available for her that night. - She was told by the CEO they had negotiated with Sister Facility A to meet the next day and swap patients. - She never heard the CEO offer client #4 or her father the option to stay in a hotel that night. G. Example of failure to coordinate with LME/MCO representative: Review on 10/18/21 of FC#10's record revealed: - Admitted 4/21/21 and discharged 9/29/21 - 14 years old - Diagnoses: DMDD, Major Depressive Disorder, Trauma and PTSD Review on 10/18/21 of an email sent to the	V 314		

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V 314	Continued From page 53 Division of Health Service Regulation by the LME/MCO revealed: - LME/MCO representative sent an email to the facility's Acting Director of Clinical Services (ADCS) on 9/22/21 about an alleged assault on FC#10 Interview on 10/18/21 the LME/MCO representative reported: - It was brought to her attention FC#10 was assaulted at the facility in September 2021 - Reached out to the facility's (ADCS) on 9/22/21 and received no response Interview on 10/19/21 the facility's (ADCS) reported: - seemed like the LME/MCO representative reached out to her about an alleged assault on FC#10 - she did not recall reaching back out to the the LME/MCO representative Multiple interviews from 10/7/21 through 10/26/21 revealed the following staff have resigned: - Patient Advocate last day was supposed to be 10/25/21 and was escorted out on 10/18/21 - Chief Medical Officer last day 10/22/21 - Director of Quality Compliance and Risk Management last day 10/28/21 - Program Coordinator last day 10/29/21 - Acting Director of Clinical Services last day 11/18/21 Review on 10/26/21 of the facility's Plan of Protection dated 10/26/21 and signed by the CEO revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? 1. Verification that all providers have	V 314		

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V 314	Continued From page 54 access/remote access to the Electronic Health Record will be completed by end of the day today, 10/26/21. Completion of (Computerized Physician Order Entry) CPOE Training and how to enter orders electronically will be completed by end of the day today, 10/26/21. RNs (Registered Nurse) and Therapists will be trained on ensuring Physicians are ordering all discharges and transfers to other levels of care. 2. All direct care staff will be trained on expectations and responsibilities for their position. 3. Prior to being admitted to program clear expectations for all items that would be considered contraband including piercing's will be clearly explained to families, patients with piercing's in currently will be assessed by physicians for safety 4. All Direct care staff will be trained on all aspects of verbal de-escalation, milieu management, leadership, roles, responding and responsibilities in codes. 5. All direct care staff will be trained on all aspects of seclusion and restraint to include observations during and after interventions. -Describe your plans to make sure the above happens. 1. HIM (Health Information Manager) will audit all physicians and provider orders. HIM will communicate with CMO/(Chief) Medical Director when providers are not completing audited documentation and report findings in (Quality Assurance Performance Improvement) QAPI. 2. Direct care staff trainings will be completed to 100% of all staff working. Staff not completing trainings will not be placed on the schedule. Trainings and competencies will be maintained in the HR (Human Resources) file and added to training tracking form which is reported out in QAPI.	V 314		

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V 314	Continued From page 55 3. Physician's order will be required for patients to maintain current piercing's. 4. Physicians/providers not completing trainings will not be placed on the schedule." This deficiency constitutes a re-cited deficiency and must be corrected. Clients ranged in ages from 12-17 with diagnoses of Post Traumatic Disorder (PTSD), Major Depression, Disruptive Mood Dysregulation, Attention Deficit with Hyperactive Disorder (ADHD), Schizophrenia and Oppositional Defiant Disorder (ODD) had multiple occasions where they had not received either group or individual therapy once a week as noted in their treatment plans. Client #4's transfer/admission between Sister Facility A and Strategic Behavioral Center-Garner was not coordinated effectively amongst her system of care which included therapist, facility staff, MCO representatives and Guardians. This lack of coordination resulted in client #4's guardian spending more than 9 hours transporting her between the two facilities and returning back to their home. Client #4 was denied admission to Strategic Behavioral Center-Garner on 8/31/21. The CEO said client #4 was not scheduled for admission on that date. FC#11's delivery of services for admissions were communicated between a care coordinator and a therapist. The CEO failed to exhibit competency by transferring FC#11 without discharge from the PRTF to the acute unit for safety purposes. This transfer was completed without guardian consent and a physician's order. FC#10 reported being assaulted in September. The LME/MCO representative reached out to the facility's therapist about the assault with no response as of the end of this survey. The CEO allowed female clients from the 300 hall to retrieve items from the	V 314		

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V 314	Continued From page 56 contraband closet such as fake eyelashes and a nose piercing without consulting with a physician to determine safety and hygiene risk. One client had complained of eye irritation as the clients were allowed to use hair gel as an adhesive on their eyes. The CEO instructed staff to contact the Police for an incident on 9/25/21 where client #1 was placed in handcuffs due to being combative and non compliant with staff orders. Multiple staff working on 9/25/21 did not exhibit competency in use of alternatives to restrictive interventions and seclusion and restraint while client #1 was having a behavior where she was able to leave the hall and run into the nurse's station to attack another client. The staff did not remove the client who was being targeted by client #1 from the immediate area. Multiple staff failed to initiate a physical restraint as client #1 stood up on the nurse's station countertop. Client #1 threw a clipboard, broke the window near the nurse's station and kicked opened the door between the nurse's station and the 400 hall without facility staff's intervention. Client #1 was handcuffed and placed in the isolation room. She was only monitored by the Police for an estimated 20 minutes without any facility staff present. There was no documentation that client #1 was monitored during and after the restraint in the isolation room. The facility failed to follow their policy for Seclusion and Restraint for the incident on 9/25/21. The failure of the above mentioned areas constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty in the amount of $3,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 314		

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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 observation, record review and interview, the facility failed to provide minimum staffing to access the needs & behaviors of the clients. The findings are: A. Example not enough staff present on the hall on 9/25/21: Review on 10/8/21 of client #1's record revealed: - Admission date 5/17/21 - Age : 16 - Diagnoses: Disruptive Mood	V 315	**Measures that will be put in place to correct the deficient area of practice:** Education on the Code Brown policy has been completed with all direct care staff, physicians and providers. All direct care staff have been trained on expectations and responsibilities for their position. All direct care staff have been trained on all aspects of verbal de-escalation, milieu management, leadership, roles, responding and responsibilities in codes. An additional "float" staff has been incorporated into the staffing grid to ensure compliance is always upheld. The float staff will ensure staffing compliance by replacing unit staff during break times and any other time staff need to step away from the unit. Before leaving the unit, the outgoing staff will communicate their needs via radio to the unit nurse. In the case of another unit staff needing to step off the unit, the needs will once again be communicated with the unit nurse who will then determine the best course of action. If the need is determined to be acute enough, either the House Supervisor or AOC will step in to ensure staffing compliance is upheld. House Supervisor will communicate any staff concerns to the AOC immediately for resolution.	

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V 315	Continued From page 58 Dysregulation Disorder, Conduct Disorder/Adolescent onset-type severe, Unspecified Mood Disorder, Cannabis Use Disorder and Oppositional Defiant Disorder Review on 10/20/21 of the North Carolina Incident Response Improvement System for Client #1 revealed: - Incident occurred on 9/25/21 - Provider summary: "Restrictive Intervention: Provider 09/28/2021 Patient was agitated, uncooperative, belligerent, irritable, and wanted to fight/ destroy property per the restraint documentation. Patient displayed violent self-destructive behavior, violent behavior towards others, staff assault, patient assault. Patient was restrained to prevent causing further harm to herself or others and to prevent her from destroying more property. Patient was banging on doors and windows. Police were called to help get control of patient. Patient fought the police and refused to stop banging on doors and windows. Medication was given to help calm patient, ineffective at first. Per documentation patient was administered a chemical restraint." Review on 10/20/21 of the facility's incident report for client #1 revealed: - Incident date: 9/25/21 - "Staff were unable to control the situation, so AOC (Administrator on Call) [Chief Executive Officer (CEO)] was called to permit police back up. Police were called to back up staff because the staff were unable to control residents' unsafe behavior. During police presences, patient [client #1], was placed in police handcuffs because she refused to stop kicking the unit door to go out of the hall. Patient told police "I will kick until police take me to jail."After police prompted her several times and she did not stop, she was placed in	V 315	**Measures that will be put in place to prevent the problem from occurring again**: Direct care staff trainings will be completed to 100% of all staff working. Staff not completing trainings will not be placed on the schedule. Trainings will be maintained in the HR file and added to training tracking form which is reported out in QAPI. Patient census and staffing will be discussed daily to ensure adequate staffing including the "float" position. Staffing assignment sheets will be modified to include this "float" position. The scheduling coordinator will be instructed to immediately notify the CNO in advance for challenges related to staffing. Training will occur with all direct staff to ensure all are familiar with the role of the "float" staff. House supervisors have been trained to contact AOC with any staffing concerns immediately. **Who will monitor the situation to ensure it will not occur again:** CEO CNO House Supervisors **How often the monitoring will take place:** Daily	11/17/21

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V 315	Continued From page 59 handcuffs and send to the quiet room. After police released patient, she refused to stay in the quiet room when she asked to stay. When police were preventing her from going out, she started kicking and punching the police. Resident wrestle with police until they were able to hold her. During the process, writer ask police to allow him to continue talking to patient to calm down." - Report completed by House Supervisor Review on 10/20/21 of the facility's video footage of the 300 hall before the 9/25/21 incident at 10:45 PM revealed: - 7:45 PM staff #1 was the only staff on the hall with 7 clients - The Lead Mental Health Technician #1 (MHT) was observed floating in and out of the dayroom - 8:25 PM - 9:57 PM Lead MHT #1 left off of the hall - 9:15 PM Staff #2 was in the nurse's station but never went on the floor - 10:12 PM Staff #2 went on the unit Interview on 10/20/21 staff #1 reported: - Employed since May 2017 - Shift: 7:00 PM - 7:30 AM - Worked on the 300 hall for the past month - Duties: monitoring clients, "make sure they are safe, make sure they don't get into trouble" - There were generally 6-7 clients on the 300 hall - Staff #2 was working as a new employee shadowing staff on the hall on 9/25/21 - Was told that there should be at least 3 staff on the hall but there was never 3 staff on the hall - If she was "lucky", she would have 1	V 315		

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V 315	Continued From page 60 other staff on the hall with her - There were a lot of times she worked by herself and the Lead MHT #1 or another Lead MHT would come and check on her Interview on 10/21/21 the Nurse #2 reported: - She was a contract nurse, that had worked for 2 days before the 9/25/21 incident - Duties were to shadow giving medications, documentation and the night routine - The 300 hall had 7 clients with with 2 staff and the 400 hall had 8 clients - Unsure of what the staffing ratios should be - There was 1 Lead MHT and 1 House Supervisor not sure of their duties Interview on 10/21/21 staff #2 reported: - 9/25/21 was 2nd night working on the hall - Duties were to shadow co-worker - Was working with 1 other MHT - 2 staff were assigned to the 400 hall - 1 lead staff was working, had seen the lead staff on the hall throughout the night - Not certain but did think ratio was out of compliance Interview on 10/21/21 the Lead MHT #1 reported: - Had been employed for 7 years - Had been short staffed for a while - Duties for a Lead MHT were to complete some paper work, monitor of all hall, relieve staff to take lunch breaks, respond to codes and work on a hall if short staffed - Had worked as a floater (which means working on each hall when needed) on the night of the 9/25/21 incident - Should have had 4 MHTs on the hall with 7 clients	V 315		

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V 315	Continued From page 61 Interview on 10/25/21 the Staffing Coordinator reported: - Completed the staffing assignment sheets daily - A person that was shadowing would not be considered into the hall ratio - Had not heard about the hall being short staffed - When the hall was short staff, she would call and attempt to find staff - She completed the schedule for the nurses Interview on 10/26/21 the Director of Quality Compliance and Risk Management reported: - The incident on 9/25/21 could have been handled differently - "You have to look at the staffing, their experience, stress level and fear" - There should not be a "staff shadowing on an active unit like the 300 hallway " - Need to ensure staffing is in ratio to "head off" behaviors before they escalate B. Examples of the facility out of staffing ratio based on their staff assignment sheets. Review between 10/18/21-10/26/21 of staff assignment sheets dated 10/10/21-10/18/21 revealed: - 10/10/21-500 hall night shift-census: 5, staff 1, nurse: 2 - 10/10/21-300 hall day shift- census: 6, staff:1, nurse: 1 - 10/10/21-300 hall night shift census: 6, staff: 2, nurse:1 - 10/12/21-600 hall night staff census: 5, staff 1, nurse: 1 - 10/14/21-500 hall night staff census: 5, staff: 1, nurse: 2	V 315		

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V 315	Continued From page 62 - 10/15/21-500 hall night staff census: 5, staff: 2, nurse: 1 - 10/15/21-300 hall night shift census: 6, staff: 2, nurse: 0 - 10/15/21-300 hall day shift census: 6, staff: 2, (including Lead MHT) nurse: 1 - 10/15/21-400 hall night shift census: 8, staff: 0, nurse: 1 - 10/16/21-600 hall day shift census: 5, staff: 1, nurse: 1 - 10/17/21-300 hall day shift census: 6, staff: 1, nurse: 1 - 10/17/21-300 hall night shift census: 7, staff: 2, nurse: 1 - 10/17/21-500 hall night shift census: 5, staff: 1, nurse: 1 - 10/17/21-500 hall day shift census: 5, staff: 1, nurse: 1 - 10/17/21-600 hall day shift census: 5, staff: 1, nurse: 1 - 10/18/21-300 hall night shift census: 5, staff: 1, nurse: 1 - 10/18/21-500 hall night shift census: 5, staff: 1, nurse: 2 Interview on 10/25/21 the House Supervisor reported : - Staffing ratio should be 2:6 on the Psychiatric Residential Treatment Facility (PRTF) - PRTF would be short staffed when there was a call out - Not sure how often the PRTF was short staffed Interview on 10/20/21 staff #1 reported: - Was told that there should be at least 3 staff on the hall but there was never 3 staff on the hall - If she was "lucky", she would have 1 person on the hall with her	V 315		

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V 315	Continued From page 63 - There were a lot of times she worked by herself and a Lead MHT would check on her Interview on 10/19/21 Former Staff #9 reported: - She was employed as a MHT Lead - Her last day worked was three weeks ago - She worked on the hall by herself "always." - The unit was "always understaffed," most of the shifts that she worked for the duration of the shift - "We were outnumbered 2/12 (2 staff/12 clients) ratio, on the 500 and 600 hall. Interview on 10/19/21 Lead MHT #2 reported: - In the last 3 months, he's worked on the acute hall 3 times by himself. - There were 6-10 clients when he worked alone - Worked PRTF on the girl's hall a week ago and he was by himself Interview on 10/26/21 staff #6 reported: - Employed as a MHT in January of 2021 - Had worked on the 500 hall by herself. - On 500 hall, when she worked alone, there were 5 boys on the hall. This occurred two weekends ago. - Had been short staffed for the past couple of weeks Interview on 10/25/21 the Program Coordinator reported: - Had been employed since 2017 - Worked many times over the last few months out of ratio on the halls - The census has dropped since the "State" has been in doing their surveys - Worked six days a week	V 315		

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V 315	Continued From page 64 - Prior to "the State" coming in the last few weeks, four of six days he worked, they were out of ratio - Many staff had worked alone on the units - Last worked alone about a month ago on the 300 hall and had 7-8 clients - That same shift another staff was alone on the 400 hall with 7-8 clients - There was a lack of staff and lots of "call outs" - Used to know what was going on with the facility, but had been taken out of those conversations in the last few months - Not been involved with the staffing of the unit - Had resigned recently due to the way the facility has been operated in the last few months. - Last day will be 10/29/21. Interview on 10/21/21 the Chief Medical Officer (CMO) reported: - Had been the CMO for three years - Heard lots of complaints from the MHT staff about staffing issues - Staff were "pissed off" because they are short staffed and having to work shifts alone - The CEO "doesn't care, it's a money saving game" - "It's intentional, feels like they are staffing under" to save money - "The practice is risky in what they are doing" - Many staff had resigned that had been there for years because of the CEO's management - The CEO was "pushing" to increase admissions while not having enough staff to meet their needs - There were not enough MHTs, nurses and therapists to increase the census	V 315		

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V 315	Continued From page 65 - "How can you run a hospital with new people and no training" - "It's a revolving door there" - "Nurses come and go, it's like a hotel, they leave because they don't have support" - Had resigned to the "culture" there and was "fed" up - Last day as CMO was 10/22/21 Interview on 10/26/21 the Director of Quality Compliance and Risk Management reported: - With regard to staffing ratios, she is unaware of the unit staffing ratios and if the units were out of ratio - She was not on the unit unless she had a client specific issue - She had been told by staff that there had been issues with the staffing ratios out of compliance - Several staff reported to her that they were instructed by the CEO not to talk with her about concerns on the unit Interview on 10/25/21 the CEO reported: - They did not increase census on the PRTF until staff was trained, (following the 9/25/21 incident) - Increased to a maximum of six on each female hall (300 & 400) - Staffing Ratios were running really well - However, due to a surge in Coronavirus Disease (COVID), a high number of call outs occurred and they tried to keep PRTF staffed - "We do a decent job with staffing on the PRTF" - Was unaware of any incident when there was only one staff working on the hall - On 9/25/21 was not sure why staff #1 would be working alone on the hall - Staff #2 was a new employee shadowing	V 315		

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V 315	Continued From page 66 on 9/25/21 which means she would have been with staff #1 observing and not counted as ratio - Came in every morning and reviewed the staffing sheet, and requested the call out list. - When there was a call out, she said they called additional people to come in - Was unaware that concerns had been voiced regarding deficient staffing ratios in the classrooms - Not aware that MHT were on their phones or distracted during class time - No one had reported this information - Teachers reported to the Director of Utilization Review - Have "amped" up pay for MHT staff to bring in more qualified staff - Had enough staff to maintain the entire facilty for the census they had - Staffing with nurses had been more challenging and using an agency for contract nurses C. Example of non compliance with 2:6 staffing ratio in the educational setting: Review on 10/20/21 of the "Staff-Student Ratio Report" revealed: - 9/7/21 300 hall partially staffed 1 staff/ 6 clients until 2nd staff arrived at 8:56 AM - 9/8/21 300 hall 1 staff/6 clients - 9/8/21 400 hall 3 staff/11 clients - 9/9/21 300 hall 1 staff/6 clients - 9/9/21 400 hall 3 staff/11 clients - 9/13/21 400 hall 1 staff/11 clients - 9/14/21 300 hall 1 staff/7 clients - 9/14/21 400 hall 2 staff/10 clients Observation and Tour of the facility classrooms on 10/20/21 between 1:00 PM -3:00 PM revealed: - Classroom 1: one teacher and one	V 315		

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V 315	Continued From page 67 MHT/4 clients - Classroom 2 : one teacher and one MHT/7 clients - Classroom 3: one teacher and one MHT/9 clients - Classroom 4: one teacher and one MHT/7 clients Interview on 10/19/21 the Teacher reported: - Had issues with the staffing ratios in her class often - Staff were not present inside the classroom. Lots of times the staff stood outside the classroom door looked inside, not even in the classroom - When they were in the classroom they mostly were on their telephones, ate and drank - Have been told they were considered ratio and then told again they were not - Had reported this to her supervisor and she reported it to her boss, Director of Utilization Review Interview on 10/19/21 the Director of Education reported: - Clients "almost always never come with the required ratios" - Teachers complained to her the staff stood outside the door during class - When there was not enough staff and the clients have behaviors with no staff to intervene , this took away from their instruction time. - Had spoken to her direct supervisor regarding this issue - This was happening so much she asked her teachers to start keeping a daily log of when the clients were in class out of ratio. - Went on the floor several times a week and the staffing was always out of ratio. - MHTs complained to her about not having	V 315		

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V 315	Continued From page 68 enough staff to cover the shifts. D. Another example of the facility being out of the staffing ratio: Review on 10/18/21 of Former Client #10's (FC) record revealed: - Admitted 4/21/21 and discharged 9/29/21 - 14 years old - Diagnoses of Disruptive Mood Dysregulation Disorder, Major Depressive Disorder, Trauma and Post Traumatic Stress Disorder Interview on 10/19/21 FC#10 reported: - Discharged 9/29/21 - The facility was under staffed - Resided on the 400 hall - Supposed to be 1 staff to 3 clients - Staff #7 worked alone on the hall sometimes - Recalled an incident that happened September 2021. Staff #7 worked alone with 12 clients. Client #13 attacked FC#10 from behind. Staff #7 tried to break them up and got his glasses broken & his face was scratched up Interview on 10/22/21 staff #7 reported: - Worked at the facility 15 months - Worked the 7 PM - 7 AM shift - Recalled the incident on 9/21/21. - He was alone on the 400 hallway with 10 - 12 clients. - He made the CNO aware he was the only staff present. - He told her it was not safe for him or the clients for one staff to be on the hall. - She told him to view the staff schedule to see who was supposed to work with him. - He explained staff schedule was not	V 315		

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V 315	Continued From page 69	V 315		

always accurate.

- The CNO requested he went to his assigned hall or "be terminated."
- He returned to the 400 hall and less than 5 minutes on the hall a fight broke out.
- Client #13 went in FC#10's bedroom and hit her for no reason. He went to break up the fight between client #13 & FC#10 and got punched several times in the face by client #13. She broke his glasses and he received bruises to the face. He screamed really loud for help and dayshift was in the process of leaving and heard him scream. Dayshift staff intervened, if not "I'm not sure what would have happened."
- He went to the front office to speak with the CNO. He was not able to see well because his glasses were broken.
- After he explained to her what happened, she asked him what he wanted her to do. He explained he could not work alone. She allowed him to leave work early that day.
- Within the last week, he worked alone with 8 - 9 girls on the 400 hallway

Interview on 10/25/21 the CNO reported:

- Recalled the September 2021 incident. Staff #7 came to her office when he arrived on shift.
- He said he was the only staff on the hall. She requested he check the staff schedule and come back to see her.
- When he returned to her office, he said a patient hit him and he wanted to go home. Dayshift staff were still present on the hall.
- There was one night shift staff on duty.
- There were 9 clients on the hall.
- The hall was short of staff that evening because a staff called out.
- She interviewed staff and clients about the physical altercation, they all denied an

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V 315	Continued From page 70 altercation happened - She filled in and allowed staff #7 to go home Review on 10/26/21 of the facility's Plan of Protection dated 10/26/21 completed by the CEO "-What immediate action will the facility take to ensure the safety of the consumers in your care? 1. PRTF census will be capped at 24 patients for 30 days 2. An additional 'float' staff will be incorporated into the staffing grid effective immediately to ensure compliance is always upheld. The float staff will ensure staffing compliance by replacing unit staff during break times and any other time staff need to step away from the unit. Before leaving the unit, the outgoing unit staff will communicate their needs via radio to the unit nurse. In the case of another unit staff needing to step off the unit, the needs will once again be communicated with the unit nurse who will then determine the best course of action. If the need is determined to be acute enough, either the House Supervisor or AOC will step in to ensure staffing compliance is upheld. 3. House Supervisor will communicate any staffing concerns to the AOC immediately for resolution. -Describe your plans to make sure the above happens. 1. Patient census and staffing will be discussed daily to ensure adequate staffing including the "float" position. 2. Staffing assignment sheets will be modified to include this "float" position. The scheduling coordinator will be instructed to immediately notify the CNO in advance for challenges related to	V 315		

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V 315	Continued From page 71 staffing. 3. Training will occur with all direct staff to ensure all are familiar with the role of the 'float' staff. 4. House Supervisors will be trained to contact AOC with any staffing concerns immediately" Clients ranged in ages from 12-17 with diagnoses which included Disruptive Mood Dysregulation Disorder, Conduct Disorder/Adolescent onset-type severe, Unspecified Mood Disorder, Post Traumatic Stress Disorder, Cannabis Use Disorder and Oppositional Defiant Disorder. Staffing ratios of 2:6 were out of compliance in both residential and educational setting on several occasions. Client census on each residential hall housed between 5-12 clients. Over a 9 day period and review of 18 total shifts, the assignment sheets noted 17 occurrences of non compliance with staffing ratios. The educational setting did not meet staffing ratios to provide safety and an effective learning environment for teachers and students. The facility staff were not inside the classroom and it was unclear whether teachers were considered in the staff/client ratio. Due to lack of staffing, one staff was injured as he tried to intervene in an incident between two clients. The staff pattern on that day was 1 staff to 12 clients. Documentation of the assignment sheets did not correlate with staff present and on duty at the time. The failure of the above mentioned areas constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty in the amount of $3,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 315		

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V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human	V 536	V 536 Begins **Measures that will be put in place to correct the deficient area of practice:** Re-education of restraint/ seclusion processes is being completed with all direct care staff. All direct care staff are being trained on all aspects of verbal de-escalation, milieu management, leadership, roles, responding and responsibilities in codes. All direct care staff will be trained on all aspects of seclusion and restraint to include observations during and after interventions. CPI training is being completed with all direct care staff at least every 6 months. One Hour Face to Face education has been reviewed with RNs covering processes and documentation requirements. Physician/ provider education has been provided on restraint/ seclusion documentation requirements including guidelines for restraint/ seclusion orders. 100% of all restraint/ seclusion documentation will be reviewed for the next 60 days or until 98% compliance has been achieve for 4 consecutive weeks. Monthly audits of restraint/ seclusion documentation will continue and outcomes will be reported in QAPI, Med Exec and Governing Board Meetings.	11/12/21

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V 536	Continued From page 73 behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an	V 536	Nursing staff not completing the required documentation will receive follow up by the CNO or designee. Documentation of the follow up provided will be maintained in the personnel file. Physicians/ providers who are found not completing required documentation or appropriate orders will receive follow up by the CMO, Medical Director or supervising physician. PI Indicators have been established and reporting of audits will be reported in QAPI Meetings, Med Exec and Governing Board Meetings. Direct care staff trainings will be completed to 100% of all staff working. Staff not completing trainings will not be placed on the schedule. Trainings will be maintained in the HR file and added to training tracking form which is reported out in QAPI. **Title of the person responsible for implementing the acceptable plan of correction:** CEO CNO House Supervisors Medical Director **Date by which all corrective actions will be completed and the monitoring system will be in place:** V 536 Ends	11/17/21

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V 536	Continued From page 74 instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may	V 536		

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V 536	Continued From page 75 request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on interview and record review the facility failed to ensure five of five staff (#1, #2, Nurse #1, Nurse #2 and House Supervisor) working during an incident demonstrated competency in alternatives to restrictive interventions and one of five staff (#1) training in alternatives to restrictive interventions was expired. The findings are: Review on 10/11/21 of Nurse #1's record revealed: - Hire date of 8/30/21 - Crisis Prevention Institute (CPI) training completed 1/12/21 Review on 10/24/21 of Nurse #2's record revealed: - Hire date of 9/24/21 - CPI training completed 9/21/21 Review on 10/11/21 of House Supervisor's record	V 536		

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V 536	Continued From page 76 revealed: - Hire date of 2/19/18 - CPI refresher training completed 5/20/21 Review on 10/24/21 of staff #1's record revealed: - Hire date of 5/18/17 - CPI training expired 3/12/21 Review on 10/24/21 of staff #2's record revealed: - Hire date of 8/3/21 - CPI training completed 9/17/21 Below are examples of staff not demonstrating competency in alternatives to restrictive interventions during an incident on 9/25/21: Review on 10/20/21 of the Facility Incident Report for client #1 revealed: - Incident date: 9/25/21 - "Staff were unable to control the situation, so AOC (Administrator on Call) [Chief Executive Officer (CEO)] was called to permit police back up. Police were called to back up staff because the staff were unable to control residents' unsafe behavior. During police presences, patient [client #1], was placed in police handcuffs because she refused to stop kicking the unit door to go out of the hall. Patient told police "I will kick until police take me to jail."After police prompted her several times and she did not stop, she was placed in handcuffs and sent to the quiet room. After police released patient, she refused to stay in the quiet room when she asked to stay. When police were preventing her from going out, she started kicking and punching the police. Resident wrestle with police until they were able to hold her. During the process, writer ask police to allow him to continue talking to patient to calm down." - Report completed by House Supervisor	V 536		

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V 536	Continued From page 77 Review on 10/11/21 of a Police report regarding client #1 dated 9/25/21 revealed: "Reporting Party Statement [Staff #1] stated the incident began over two patients not wanting to go back to their original hall that they were transferred from. [Staff #1] advised that [client #1] saw a certain patient in the lobby area & tried to go after her to fight her. In the process of [client #1] trying to reach the other patient, a door was damaged & the door window was kicked out of same. After that initial incident occurred, the other patients on the hallway became angry and began throwing items throughout the hallway. Officer Involvement: While on scene, [client #1] became violent again & began kicking a door in order to get out of the hallway. [Client #1] was then placed in handcuffs & escorted to an isolated room. The nurse then advised that they would administer [client #1] a shot to calm her down. After the shot was given to [client #1], the handcuffs were removed. [Client #1] then attempted to leave the isolated room at which time the nursing staff advised officers that she was not to leave the room. [Client #1] became violent & had to be escorted back into the room by myself & [Police Officer #2]. Once back in the room [client #1] began assaulting [Police Officer #2]. [Police Officer#2] then used the spear technique to maintain a safe distance between him & [client #1]. [Client #1] then proceeded to assault [Police Officer] again at which time a restraint technique was applied by [Police Officer #2] to stop the assault by [client #1]. The nursing staff then took control of [client #1] after sometime & law enforcement assistance was no longer needed. The watch commander, [Lieutenant] was notified of this incident by [Police	V 536		

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V 536	Continued From page 78 Officer #2]. No further information at this time." Review on 10/20/21 at 10:30 AM of the video footage from the 9/25/21 incident on the 300 hall revealed that from 9:15 PM until 12:21 AM there were multiple occasions where staff #1, staff #2, Nurse #1, Nurse #2 and the House Supervisor did not exhibit competency in Training in Seclusion, Physical Restraint and Isolation Time-out with the escalating behaviors of the clients on the hall. Multiple clients were engaging in verbal and physical aggression and staff did not intervene to prevent futher behaviors leading to a response from the Police to address the clients behaviors. Interview on 10/18/21 the House Supervisor reported: - A code purple was called on hall 300. - They couldn't get control of the hall. - Called the AOC - The AOC for 9/25/21 was the CEO. - Informed the CEO that all resources had been exhausted. - The CEO stated she was okay with him calling the Police. Interview on 10/21/21 Nurse #1 stated: - 9/25/21 was her second day working alone. - She was a contract nurse through another agency. - There were two Mental Health Technician (MHT) staff on the 300 hall that shift. - Staff #2 was "kind of scared" so she stayed out at the nurse's station. Interview on 10/18/21 Nurse #2 stated: - Worked as a contract nurse - 9/25/21 was her second day of training	V 536		

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V 536	Continued From page 79	V 536		

and first day on the unit.
- Was trained under Nurse #1.
- Client #1 burst through the door to the nurse's station and it "got out of hand."
- Police were called because the clients were attacking staff #1 and she was hit in the head with the clip board and the window was broken.
- Didn't feel like she should have gone on the hall to assist since it was her second day of training.

Interview on 10/18/21 staff #2 stated:
- was her second night working on the 300 hall
- Did not remember what she was doing as to why she was sitting at the nurse's station and not on the hall with staff #1
- She was shadowing staff #1 on that shift and the Lead MHT #1 was floating between halls.
- Witnessed a co-worker being beat in the head with a clip board by a client on hall 300
- Was intimidated by a couple of the clients on the hall

Interview on 10/21/21 the Police Officer #1 stated:
- Responded to an incident at the facility on 9/25/21.
- Responded because the clients were busting out windows and not following staff instruction
- Upon arrival the unit was in "disarray".
- The glass in the window leading to the nurse's station was broken out.
- The clients roamed the hall freely.
- "Maybe two staff"on the hall at that time.
- Appeared to be 7 or 8 clients.
- Some clients were screaming and yelling and they were not listening to the staff.

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V 536	Continued From page 80 - Went to the end of the hall where the loudest clients were located. - He tried to talk to them and listen to their side. - Tried to get them back in their room and they refused, so he continued to just listen to them. - He and the other Officers were waiting on staff to tell them what to do. - The staff were just standing around. - One staff did try to get them back in her room and she could not get the clients to cooperate. - Once a supervisor was on the scene, the staff wanted the Officers to help get the clients in their rooms. - The clients continued to be loud and did not listen to staff. - Then at one point, client #1 walked toward the broken glass window at the nurse's station and she was yelling and screaming then started kicking the door to the nurse's station. - As she kicked at the door, it was coming open. - Told her to stop or he would put her in handcuffs - Client #1 said, "put me in cuffs." - During this, no staff was immediately around him. - There was staff in the nurse's station. - Then placed client #1 in handcuffs due to her continuing to kick the door - He asked staff for a place to put client #1. - A male staff (House Supervisor) came in and told him to place her in a room that had padded walls (isolation room). - The door to this room did not lock so another Officer had to stand by the door with his foot on the door to keep her from getting out as she was still continuing to kick the door.	V 536		

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V 536	Continued From page 81 - The Officer's foot was holding her in so she was not able to kick it open. - The male staff he was moving around the unit a lot, "I did not see staff stand by the door with the Officer, but the staff was just walking around." - He went back to the hallway and another Officer (Police Officer #2) arrived. - He talked to the clients to let them blow off steam. - One staff (staff #1) stayed at the end of the hall and talked to the clients too. - After a while, the staff came up with a plan to sedate client #1. - While in the isolation room client #1 remained in handcuffs. - After client #1 received her medication, Police Officer #2 tried to talk to her, informing her they would remove the handcuffs if she remained calm - During this time, the nurse was in and out of the isolation room, but not sure if she was checking client #1's vitals. - Once they got client #1 to stand and removed the handcuffs, client #1 assaulted one of the Officers. - Client #1 pushed forward toward Police Officer #2 who was in the doorway. - Police Officer #2 stood in front of another Officer to block client #1, but she pushed/hit and kicked the Officer - They got her back in the isolation room and Police Officer #2 told her to calm down but she tried to punch, kick and scratch him - Police Officer #2 pushed her back in the room - Police Officer #2 had to use "force -the spear technique" - During this time the staff started to come to assist	V 536		

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V 536	Continued From page 82 - The staff was around the door at the time. - The nurse and two male staff were right outside the door. - The force was used to keep her from pushing out of the isolation room they used the" arm bar technique." - The staff then came into the isolation room and they did not intervene. - The staff was just saying her name but never saw the staff restrain her. - Client #1 eventually calmed down and he left the area. Interview on 10/21/21 Police Officer #2 stated: - Responded to the facility on 9/25/21 later as he was not on duty, but heard the call and spoke with Police Officer #1 and could tell the situation was hostile and he asked him to come help them out. - Arrived at the facility around 11:30-11:45 pm - The clients were verbally "hostile." - Upon arrival a few clients were in the hallway with trash and stuff thrown everywhere. - The clients were sitting on the ground cursing at the staff who had "zero control of the situation." - An Officer on the scene told him they had someone in the "holding cell" (isolation room) who was irate and hostile. - Went down the hall and talked to client #1 in the isolation room and she kept asking to take the handcuffs off. - Told her there was a reason she was in them - Staff then brought in a shot and she was ok with the shot and asking for it. - One staff (Nurse #2) said she was a new contractor 1st or 2nd night working and said, "I	V 536		

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V 536	Continued From page 83 don't even know what is going on." - Asked Nurse #2 if she would be come back and she said "no." - Noticed the window was broken near the office area. - Never saw the staff trying to control client #1 while he was present in the facility - While he was observing client #1 in the isolation room, only saw Nurse #2 come in and out, and the officers were the ones handling client #1. - Client #1 was sitting on the floor handcuffed and no other staff members around . - Then a nurse came to give client #1 a second shot. - 1st shot in left arm and client #1 was "ok." - Then a male staff snatched at her arm to roll her sleeve up for the injection. - Told the staff not to do that and he needed to "gently roll her sleeve because she is already irate." - Made a deal with client #1 and if she calmed down he would take the handcuffs off. - Took the handcuffs off and she walked out to the main hall - Another Officer was standing in the door and client #1 hit the Officer in his back. - An Officer then tried to grab her hand and she swung at him so he then stepped in and she swung at him saying, "get the f**k off me." - Proceeded to block her hand and "put her in an arm bar" - "Not sure what staff was doing, I was too busy blocking punches." - Got client #1 back in the room with "a wrist lock on her face." - Let client #1 go, she then jumped at him and kicked him twice - Told client #1 to back up, she tried to get	V 536		

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STRATEGIC BEHAVIORAL CENTER-GARNER	3200 WATERFIELD DRIVE GARNER, NC 27529

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V 536	Continued From page 84 to the door and she swung and hit him in the shoulder - Client #1 tried to swing again, then backed her against the wall "with my elbow in her sternum against the wall" - Client #1 was reaching with other hand scratching and tried to bite him - Then staff came in 30-40 seconds later, just saying client #1's name over and over - It was two males and one female staff that came in the isolation and and said they got her. - "I said finally, where the h**l y'all been." - Staff had "zero control, I have seen more control with 5th grader on 5th grader supervision." - "It was a d**n mess" - "I showed up to the clean up because they (staff) were drowning" - Never been in the middle of a facility, jails, detention and etc. with no staff trying to do anything during that kind of situation - One staff (staff #1) had a good rapport with the clients, the "rest were just bumps on a log." - "In my opinion, they (staff) should have a hold of her (client #1) a*s, not me to have to control this situation" - The new staff (Nurse #2) seemed "over her head" and the other staff was "completely stand off and wanted us (Police Officers) to do their job for them" - There needs to be something done, "this has been this worst I have seen this facility" and he had been going there since they opened years ago. Interview on 10/21/21 the Chief Medical Officer (CMO) stated: - Was just made aware of the incident on 9/25/21 yesterday (10/20/21) from a colleague	V 536		

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V 536	Continued From page 85 - Been in Psychiatric treatment for 21 years - Police should not be in a hospital, they can not come on to a unit and restrain someone, "it illegal." - Staff should have handled the situation and contacted the doctor. - If therapy does not work, you do not use the Police, "that doesn't work." - Not sure whose decision it was to call the Police, but that should not have happened. - Staff needed constant training to handle the clients - "How can you run a hospital with new people and no training." Interview on 10/25/21 the Program Coordinator stated: - He had been the trainer for Crisis Prevention Interventions (CPI) for the staff - Training is very clear that they are a psychiatric hospital. - Staff are to keep the clients safe and that is difficult to do when the staff were not equipped to do so. - The nurses have been "reluctant" in the past to use their training. - The staff definitely understand their role and to intervene. - If a client was escalating, the doctor should have been contacted regarding the client's behavior. - Would not have contacted the Police as this could have been handled by staff if they had the correct amount of staff on duty. Interview on 10/26/21 the Director of Quality Compliance and Risk Management stated: - Was on vacation during the incident that occurred on 9/25/21	V 536		

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V 536	Continued From page 86 - Had since reviewed the video and felt the situation could have been handled differently from the beginning of the behaviors starting. - If the staff would have deescalated that situation from the beginning and removed client #1, that would not have led to further behaviors. - The situation "spiraled" and should not have led to the Police being called. - Did not see the physical aggression from other clients - Police were called per the direction of the CEO. - The physical aggression was from client #1 and no other clients, not a "riot" - The CEO told her she was called by the House Supervisor that evening saying there was not enough men around to handle the situation with client #1. - The CEO then told the House Supervisor to call the Police to help control the unit. - This type of peer on peer conflict is"typical" behavior in a Psychiatric Residential Treatment Facility (PRTF). - This was a "code purple," which is for a "combative situation." - Had been employed for three years and never heard of a "code brown" being called. - The Police should not have been called in this situation. Interview on 10/25/21 the CEO stated: - She was the AOC on call on 9/25/21 when the incident occurred on the 300 hall. - The House Supervisor called her a little after 10:00 PM and told her the girls unit was attacking staff and jumping on staff. - The girls were attacking staff and staff was injured. - The House Supervisor stated he had already called the police when he called her.	V 536		

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V 536	Continued From page 87 - The House Supervisor had used the "code brown" which is when the staff is given the authority to call the police during a "riot" - The staff had utilized all other options prior to calling the Police. - Never "Ok" with the Police being called on the unit, but things were "pretty heightened." - Called back in thirty minutes and things had been resolved - Reviewed the video with the staff afterwards to determine what could have been done differently. - The staff involved that evening did a good job during the incident. - Concerned about how several staff just stood outside the nurse's station and not deal with the verbal escalation going on. - Not aware that many Police had responded - The staff did not respond to the situation as they were trained to do so - After the incident heard that staff working that evening were anxious and concerned about being harmed by the clients. - Was not aware there was a shadow employee working that evening alone with one other staff. - Staff #2 had been trained in Alternative to Restrictive Interventions by the time she would have shadowed and should have engaged in helping deescalate the situation. This deficiency is cross referenced into: 10 A NCAC 27G .1901 Scope (V314) for a Type A1 rule violation and must be corrected within 23 days.	V 536		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO	V 537		

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V 537	Continued From page 88 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include,	V 537	V 537 Begins **Measures that will be put in place to correct the deficient areas of practice:** Re-education of restraint/ seclusion processes is being completed with all direct care staff. All direct care staff have been trained on all aspects of verbal de-escalation, milieu management, leadership, roles, responding and responsibilities in codes. All direct care staff will be trained on all aspects of seclusion and restraint to include observations during and after interventions. CPI training is being completed with all direct care staff at least every 6 months. One Hour Face to Face education has been reviewed with RNs covering processes and documentation requirements. Physician/ provider education has been provided on restraint/ seclusion documentation requirements including guidelines for restraint/ seclusion orders. 100% of all restraint/ seclusion documentation will be reviewed for the next 60 days or until 98% compliance has been achieve for 4 consecutive weeks. Monthly audits of restraint/ seclusion documentation will continue and outcomes will be reported in QAPI, Med Exec and Governing Board Meetings.	

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V 537	Continued From page 89 but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence	V 537	**Measures that will be put in place to prevent the problem from occurring again**: 100% of all restraint/ seclusion documentation will be reviewed for the next 60 days or until 98% compliance has been achieve for 4 consecutive weeks. Monthly audits of restraint/ seclusion documentation will continue and outcomes will be reported in QAPI, Med Exec and Governing Board Meetings. Nursing staff not completing the required documentation will receive follow up by the CNO or designee. Documentation of the follow up provided will be maintained in the personnel file. Physicians/ providers who are found not completing required documentation or appropriate orders will receive follow up by the CMO, Medical Director or supervising physician. PI Indicators have been established and reporting of audits will be reported in QAPI Meetings, Med Exec and Governing Board Meetings. Direct care staff trainings will be completed to 100% of all staff working. Staff not completing trainings will not be placed on the schedule. Trainings will be maintained in the HR file and added to training tracking form which is reported out in QAPI. **Who will monitor the situation to ensure it will not occur again:** CEO CNO House Supervisors CMO Medical Director **How often the monitoring will take place:** Daily/ Weekly/ Monthly	11/17/21

			V 537 Ends	

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V 537	Continued From page 90 by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher	V 537		

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V 537	Continued From page 91 instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on interview and record review the facility failed to ensure five of five staff (#1, #2, Nurse #1, Nurse #2 and House Supervisor) working during an incident demonstrated competency in Seclusion, Physical Restraint and Isolation Time-Out and one of five staff (#1) training in Seclusion, Physical Restraint and Isolation Time-Out had expired. The findings are: Review on 10/11/21 of Nurse #1's record revealed: - Hire date of 8/30/21 - NCI training completed 1/12/21	V 537		

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V 537	Continued From page 92 Review on 10/24/21 of Nurse #2's record revealed: - Hire date of 9/24/21 - CPI training completed 9/21/21 Review on 10/11/21 of House Supervisor's record revealed: - Hire date of 2/19/18 - NCI refresher training completed 5/20/21 Review on 10/24/21 of staff #1's record revealed: - Hire date of 5/18/17 - CPI training expired 3/12/21 Review on 10/24/21 of staff #2's record revealed: - Hire date of 8/3/21 - NCI training completed 9/17/21 Review on 10/20/21 of the Facility Incident Report for Client #1 revealed: - Incident date: 9/25/21 - "Staff were unable to control the situation, so AOC (Administrator on Call) [Chief Executive Officer (CEO)] was called to permit police back up. Police were called to back up staff because the staff were unable to control residents' unsafe behavior. During police presences, patient [client #1], was placed in police handcuffs because she refused to stop kicking the unit door to go out of the hall. Patient told police "I will kick until police take me to jail."After police prompted her several times and she did not stop, she was placed in handcuffs and send to the quiet room. After police released patient, she refused to stay in the quiet room when she asked to stay. When police were preventing her from going out, she started kicking and punching the police. Resident wrestle with police until they were able to hold her. During the process, writer ask police to allow him to	V 537		

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V 537	Continued From page 93 continue talking to patient to calm down." - Report completed by House Supervisor Review on 10/25/21 of client #1's Progress note dated 9/25/21 revealed: - No documentation of unsafe behaviors or physical aggression - No documentation of a restraint - No documentation of client being placed in the isolation room - No documentation of staff monitoring client throughout her time in the isolation room or after being returned to her hall throughout the night. Review on 10/25/21 of the facility policy on Seclusion and Restraint policy revealed: - "Documentation for Emergency Safety Interventions: All restraint techniques or seclusion will be documented by a registered nurse in the patient's medical record and will reflect justification, implementation and outcome of procedure (to include behavior at time of release) and shall address the failure of less restraint or seclusion. Documentation must be completed by the end of the shift on which the intervention occurs. - The Restraint or seclusion/Flow sheet must have an observation entry by the assigned staff at least every 15 minutes from initiation of the restraint or seclusion and observation of the patient must be continuous. The RN [Registered Nurse] assessment is completed at initiation and every 15 minutes, thereafter and includes, as appropriate to the type of restraint or seclusion the following: - A. signs of any injury associated with applying restraint/seclusion	V 537		

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V 537	Continued From page 94 Restraint or seclusion Guidelines: - When a patient is in the seclusion room he/she must be under CONSTANT observation of staff trained in the use of emergency safety situations. The staff members must be physically present immediately outside the seclusion room continuously assessing, monitoring, and evaluating the physical and psychological well-being of the patient in seclusion." Below are examples of staff not demonstrating competency in Seclusion, Physical Restraint and Isolation Time-Out during an incident on 9/25/21: Review on 10/18/21 at 9:38 AM of video footage from the 9/25/21 incident revealed the following approximate time frames: - 11:12 PM, client #1 was in handcuffs and placed in the isolation room by a Police Officer, two other Officers in the hallway - 11:14 PM, an Officer is seen looking into the window while he held the isolation room door shut with his foot - 11:14:58 - 11:32:39 there is no staff monitoring client #1 in the isolation room (18 minutes without being monitored by a facility staff) - 11:32 PM Nurse #1 and Nurse #2 enter the isolation room with medication in hand...appeared she did not take the oral medication - 11:41 PM Nurse #1 left the isolation room - 11:44 PM client #1 received an injection from Nurse #1 in each arm while still in handcuffs sitting on the floor, Officer inside the isolation room while staff outside the door - 11:54 PM handcuffs were removed with police as staff #3 arrived, client #1 attempted to attack the Police Officers, then the House Supervisor arrived in the room...the House	V 537		

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V 537	Continued From page 95 Supervisor and the Lead Mental Health Technician (MHT) #1 in the room with client #1 - 12:21 AM client #1 left the isolation room. Review on 10/20/21 at 10:30 AM of the video footage from the 9/25/21 incident on the 300 hall revealed that from 9:15 PM until 12:21 AM there were multiple occasions where staff #1, staff #2, Nurse #1, Nurse #2 and the House Supervisor did not exhibit competency in Training in Seclusion, Physical Restraint and Isolation Time-out with the escalating behaviors of the clients on the hall. Multiple clients were engaging in verbal and physical aggression and staff did not intervene to prevent futher behaviors leading to a response from the Police to address the clients behaviors. Client #1 was placed in the isolation room and not monitored at all times during the isolation by the staff. Interview on 10/18/21 the House Supervisor reported: - A code purple was called on hall 300. - They couldn't get control of the hall. - Called the Administrator On Call (AOC). - The AOC for 9/25/21 was the Chief Executive Officer (CEO). - Informed CEO that all resources had been exhausted. - The CEO stated she was okay with him calling the Police. Interview on 10/21/21 the Nurse #1 stated: - 9/25/21 this was her second day working alone. - She was a contract nurse through another agency. - There were two Mental Health Technician (MHT) staff on the 300 hall that shift - Staff #2 was "kind of scared" so she	V 537		

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V 537	Continued From page 96 stayed out at the nurse's station. - Was training the Nurse #2 who was in her 2nd day of orientation - She administered the chemical restraint on client #1. - As the nurse, she was supposed to check on clients every 15 minutes while in the isolation room - "Sometimes you go in the isolation room if they are calm and if not, you check through the door and ask them if they need anything." - Did not remember documenting her checks on client #1 on 9/25/21 while she was in the isolation room, but did check on her several times. - Staff were supposed to stay with the client while in the isolation room monitoring them through the door. Interview on 10/18/21 the Nurse #2 stated: - Worked as a contract nurse - 9/25/21 was her second day of training and first day on the unit. - Was trained under Nurse #1. - Client #1 burst through the door to the nurse's station and it "got out of hand." - Police were called because the clients were attacking staff #1 and she was hit in the head with the clip board and the window was broken. - Didn't feel like she should have gone on the hall to assist since it was her second day of training. - Helped give client #1 her medication after the Police handcuffed her. - Client #1 was in the isolation room for about an hour. It took a long time for her to calm down. - They did check on her, but the other nurse documented this.	V 537		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE

V 537	Continued From page 97 Interview on 10/18/21 Staff #2 stated: - 9/25/21 was her second night working on the 300 floor. - Did not remember what she was doing as to why she was sitting at the nurse's station and not on the hall with staff #1 - She was shadowing staff #1 on that shift and the Lead MHT #1 was floating between halls. - There were seven clients on the hall that evening of 9/25/21. - Client #1 had been trying to attack another client. - Not sure why client #1 was not restrained. - Witnessed a co-worker being "beat" in the head with a clip board by a client on hall 300 - Was "intimidated" by a couple of the clients on the hall. Interview on 10/21/21 the Police Officer #1 stated: - Responded to an incident at the facility on 9/25/21. - Responded because the clients were busting out windows and not following staff instruction - Upon arrival the unit was in "disarray" - The glass in the window leading to the nurse's station was broken out - The clients roamed around the hall freely. - "Maybe two staff" on the hall at that time. - Appeared to be 7 or 8 clients - Some clients were screaming and yelling and they were not listening to the staff - Went to the end of the hall where the loudest clients were located - He tried to talk to them and listen to their side - Tried to get them back in their room and	V 537		

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	20140058	A. BUILDING: _____ B. WING _____	C 10/26/2021

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V 537	Continued From page 98 they refused, so he continued to just listen to them - He and the other Officers were waiting on staff to tell them what to do - The staff were just standing around - One staff did try to get them back in her room and she could not get the clients to cooperate - Once a supervisor was on the scene, the staff wanted the Officers to help get the clients in their rooms - The clients continued to be loud and not listening - Then at one point, client #1 walked toward the broken glass window at the nurse's station and she was yelling and screaming then started kicking the door to the nurse's station - As she kicked the door it was coming open. - Told her to stop or he would put her in handcuffs. - Client #1 said, "put me in cuffs." - During this time, no staff was immediately around him. - There was staff in the nursing station. - Then placed client #1 in handcuffs due to her continuing to kick the door - He asked staff for a place to put client #1 - A male staff (House Supervisor) came in and told him to place her in a room that had padded walls (isolation room). - The door to this room did not lock so another Officer had to stand by the door with his foot on the door to keep her from getting out as she was still continuing to kick the door. - The Officer's foot was holding her in so she was not able to kick it open. - The male staff was moving around the unit a lot, "I did not see staff stand by the door with the Officer, but the staff was just walking	V 537		

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V 537	Continued From page 99 around." - He went back to the hallway and another Officer (Police Officer #2) arrived. - He talked to the clients to let them blow off steam. - One staff (staff #1) stayed at the end of the hall and talked to the clients too. - After a while, the staff came up with a plan to sedate client #1. - While in the isolation room client #1 remained in handcuffs. - After client #1 received her medication, Police Officer #2 tried to talk to her informing her they would remove the handcuffs if she remained calm. - During this time, the nurse was in and out of the isolation room, but not sure if she was checking client #1's vitals. - Once they got client #1 to stand and removed the handcuffs, client #1 assaulted one of the Officers. - Client #1 pushed forward toward Police Officer #2 who was in the doorway. - Police Officer #2 stood in front of another officer to block client #1, but she pushed/hit or kicked the Officer. - They got her back in the isolation room and Police Officer #2 told her to calm down but she tried to punch, kick and scratch him. - Police Officer #2 pushed her back in the room - Police Officer #2 had to use "force -the spear technique" - During this time the staff started to come to assist. - The staff was around the door at the time. - The nurse and two male staff were right outside the door. - The force was used to keep her from	V 537		

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V 537	Continued From page 100 pushing out of the isolation room they used the"arm bar technique." - The staff came into the isolation room and they did not intervene. - The staff was just saying her name but never saw the staff restrain her. - Client #1 eventually calmed down and he left the area. Interview on 10/21/21 the Police Officer #2 stated: -Responded to the facility on 9/25/21 later as he was not on duty, but heard the call and spoke with Police Officer #1 and could tell the situation was hostile and he asked him to come help them out - Arrived at the facility around 11:30-11:45 PM. - The clients were verbally "hostile." - Upon arrival a few clients were in the hallway with trash and stuff thrown everywhere. - The clients were sitting on the ground cursing at the staff who had "zero control of the situation." - An Officer on the scene told him they had someone in the "holding cell" (isolation room) who was irate and hostile - Went down the hall and talked to client #1 in the isolation room and she kept asking to take the handcuffs off - Told her there was a reason she was in them - Staff then "brought in a shot and she was ok with the shot and asking for it" - One staff (Nurse #2) said she was new contractor 1st or 2nd night working and said, "I don't even know what is going on" - Asked Nurse #2 if she would be coming back and she said "no" - Noticed the window was broken near the	V 537		

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V 537	Continued From page 101 office area - Never saw the staff trying to control client #1 while he was present in the facility - While he was observing client #1 in the isolation room, only saw nurse #2 come in and out, and the officers were the ones handling client #1 - Client #1 was sitting on the floor handcuffed and "no other staff members around" - Then a nurse came to give client #1 a second "shot" - 1st "shot" in left arm and client #1 was "ok" - Then a male staff "snatched" at her arm to roll her sleeve up for the injection - Told the staff not to do that and he needed to "gently roll her sleeve because she is already irate" - Made a deal with client #1 and if she calmed down he would take the handcuffs off - Took the handcuffs off and she walked out to the main hall - Another officer was standing in the door and client #1 hit the officer in his back - An officer then tried to grab her hand and she swung at him - He then stepped in and she swung at him saying, "get the f**k off me" - Proceeded to block her hand and "put her in an arm bar" - "Not sure what staff was doing, I was too busy blocking punches" - Got client #1 back in the room with "a wrist lock on her face" - Let client #1 go, she then jumped at him and kicked him twice - Told client #1 to back up, she tried to get to the door and she swung and hit him in the shoulder - Client #1 tried to swing again, then he	V 537		

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V 537	Continued From page 102 backed her against the wall "with my elbow in her sternum against the wall" - Client #1 was reaching with other hand scratching and tried to bite him - "Then staff came in 30-40 seconds later, just saying client #1's name over and over." - It was two males and one female staff that came in the isolation and said "they got her." - "I said finally, where the h**l y'all been" - Staff had "zero control, I have seen more control with 5th grader on 5th grader supervision" - "It was a d**n mess" - "I showed up to the clean up because they (staff) were drowning" - "Never been in the middle of a facility, jails, detention and etc. with no staff trying to do anything during that kind of situation" - One staff (staff #1) had a good rapport with the clients, the "rest were just bumps on a log" - "In my opinion, they (staff) should have a hold of her (client #1) a*s, not me to have to control this situation" - The new staff (Nurse #2) seemed "over her head" and the other staff was "completely stand off and wanted us (Police Officers) to do their job for them." - "There needs to be something done, this has been the worst I have seen this facility" and he had been going there since they opened years ago. Interview on 10/21/21 the Chief Medical Officer (CMO) stated: - Was just made aware of the incident on 9/25/21 yesterday (10/20/21) from a colleague - Been in Psychiatric treatment for 21 years - Police should not be in a hospital, they can not come on to a unit and restrain someone,	V 537		

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V 537	Continued From page 103 "it illegal." - Staff should have handled the situation and contacted the doctor - If therapy does not work, you do not use the police, "that doesn't work" - Not sure whose decision it was to call the police, but that should have not happened - Staff needed constant training to handle the clients - "How can you run a hospital with new people and no training?" Interview on 10/18/21 and 10/26/21 the Director of Quality Compliance/Risk Management stated: - Was on vacation during the incident that occurred on 9/25/21 - Had since reviewed the video and felt the situation could have been handled differently from the beginning of the behaviors starting. - If the staff would have deescalated that situation from the beginning and remove her, that would not have led to further behaviors - The situation "spiraled" and should have led to the police being called - Did not see the physical aggression from other clients - Police were called per the direction of the CEO - The physical aggression was from client #1 and no other clients, not a "riot" - The CEO told her she was called by the House Supervisor that evening saying there was not enough men around to handle the situation with client #1 - The CEO then told the House Supervisor to call the police to help control the unit - This type of peer on peer conflict is "typical" behavior in a PRTF - This was a "code purple," which is for a "combative situation"	V 537		

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V 537	Continued From page 104 - Have been employed for three years and never heard that of a "code brown" being called - The police should not have been called in this situation - When a client is in the isolation room, the staff were to observe the client at the window of the door - While watching the video of 9/25/21 on the 300 hall, not sure why staff was not present monitoring client #1 while in the isolation room - Clients should have constant monitoring while in the isolation room Interview on 10/25/21 the Program Coordinator stated: - He had been the trainer for Crisis Prevention Interventions (CPI) for the staff - Training is very clear that they are a psychiatric hospital - Staff is to keep the clients safe and that is difficult to do when the staff was not equipped to do so - The nurses have been "reluctant" in the past to use their training - The staff definitely understand their role and to intervene - If a client was escalating, the doctor should have been contacted regarding the client's behavior - Would not have contacted the Police as this could have been handled by staff if they had the correct amount of staff on duty Interview on 10/18/21 & 10/19/21 the Chief Nursing Officer (CNO) reported: - Should have been "constant" monitoring of client #1 by a Mental Health Technician (MHT) in the isolation room at all times Interview on 10/25/21 the CEO stated:	V 537		

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V 537	Continued From page 105 - She was the AOC on call on 9/25/21 when the incident occurred on the 300 hall - The House Supervisor called her a little after 10:00 PM and told her the girls unit was attacking staff and jumping on staff - The clients were attacking staff and staff was injured - The House Supervisor stated he had already called the Police when he called her - The House Supervisor had used the "code brown" which is when the staff is giving the authority to call the police during a "riot" - The staff had utilized all other options prior to calling the Police - Never "Ok" with the police being called on the unit, but things were "pretty heightened" - Called back in thirty minutes and things had been resolved - She reviewed the video with the staff afterwards to determine what could have been done differently - The staff who was involved that evening thought they did a good job during the incident - Concerned about how several staff just stood outside the nurse's station and not deal with the verbal escalation going on - Not aware that many police had to responded - The staff did not respond to the situation as they were trained to do so - After the incident heard that staff working that evening was anxious and concerned about being harmed by the girls - Was not aware there was a shadow employee working that evening alone with one other staff - Staff #2 had been trained in Alternatives to Restrictive Interventions by the time she would have shadowed and should have engaged in helping deescalate the situation	V 537		

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V 537	Continued From page 106 - While client #1 was in isolation, she should have been in constant observation from the staff - The client should have been monitored after the isolation by the nurse and ongoing throughout the night This deficiency is cross referenced into: 10 A NCAC 27G .1901 Scope (V314) for a Type A1 rule violation and must be corrected within 23 days.	V 537		