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MATTHEW W. WOLFE, SHAREHOLDER **Direct Dial**: (919) 323-0218

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November 15, 2021

Received by MHL & C 11/30/2021

## 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.

 $\begin{array}{c} 4873 \hbox{-} 9548 \hbox{-} 1859 v1 \\ 2957721 \hbox{-} 000002 \ 11/15/2021 \end{array}$ 

Michiele Elliott, Acting Chief Mental Health Licensure & Certification Section

Re: SBH-Raleigh, LLC

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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:
  - o Incident reporting;
  - o Staff Discipline;
  - o Restraint/Seclusion;
- Completion of extensive trainings and re-trainings for all staff, including in the following areas:
  - o Discharge process;
  - Medication orders:
  - o Incident reporting;
  - o Staff Discipline;

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- Restraint/Seclusion (including orders);
- Alternatives to restrictive interventions (CPI);
- o 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

Tay In

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

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING 20140058 10/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WATERFIELD DRIVE STRATEGIC BEHAVIORAL CENTER-GARNER GARNER, NC 27529 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFI DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE XTAG DEFICIENCY) Please note that Strategic Behavioral Center -V 000 INITIAL COMMENTS V 000 Raleigh takes these findings seriously and is fully committed towards developing effective A Follow Up and Complaint survey was strategies for compliance with regulations and completed on 10/26/21. The complaints were monitoring and evaluation activities to ensure substantiated (Intakes #NC00179281, compliance with same. #NC00179445, #NC00178447, #NC00180199. #NC00180904, #NC00181294, #NC00181505, Pursuant to your request, the corrective actions #NC00181670, #NC00181771, #NC00181950, are delineated in the following pattern: #NC00182159 and #NC00182653). Deficiencies were cited. What measures will be put in place This facility is licensed for the following service to correct the deficient area of categories: practice. 10A NCAC 27G. 1900 Psychiatric What measures will be put in place Residential Treatment for Children and to prevent the problem from Adolescents. Halls 300, 400, 500 and 600 were occurring again. licensed under this category Who will monitor the situation to 10A NCAC 27G, 6000 Inpatient Hospital ensure it will not occur again. Treatment for individuals who have Mental Illness How often the monitoring will take or Substance Abuse Disorders. Halls 100, 200, 700 and 800 were licensed under this category place. 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 V 105 Begins category 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and 1) Policies were reviewed, and staff have Adolescents. Staff will be identified using the been provided with re-education of the policies and processes. letter A and their professional titles. This location will be identified as Strategic Behavioral Center-Garner in the report. V 105 27G .0201 (A) (1-7) Governing Body Policies V 105 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:

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

STATE FORM

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FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ C B WING 20140058 10/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WATERFIELD DRIVE STRATEGIC BEHAVIORAL CENTER-GARNER GARNER, NC 27529 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFI REGULATORY OR LSC IDENTIFYING INFORMATION) TAG XTAG DEFICIENCY) Please note that Strategic Behavioral Center-**INITIAL COMMENTS** V 000 V 000 Raleigh takes these findings seriously and is fully committed towards developing effective A Follow Up and Complaint survey was strategies for compliance with regulations and completed on 10/26/21. The complaints were monitoring and evaluation activities to ensure substantiated (Intakes #NC00179281, compliance with same. #NC00179445, #NC00178447, #NC00180199, #NC00180904, #NC00181294, #NC00181505, Pursuant to your request, the corrective actions #NC00181670, #NC00181771, #NC00181950, are delineated in the following pattern: #NC00182159 and #NC00182653). Deficiencies were cited. What measures will be put in place This facility is licensed for the following service to correct the deficient area of categories: practice. 10A NCAC 27G. 1900 Psychiatric What measures will be put in place Residential Treatment for Children and to prevent the problem from Adolescents. Halls 300, 400, 500 and 600 were occurring again. licensed under this category Who will monitor the situation to 10A NCAC 27G, 6000 Inpatient Hospital ensure it will not occur again. Treatment for individuals who have Mental Illness How often the monitoring will take or Substance Abuse Disorders, Halls 100, 200. place. 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 V 105 Begins Facility A is licensed for the following service category 10A NCAC 27G .1900 Psychiatric 1) Policies were reviewed, and staff have Residential Treatment for Children and been provided with re-education of the Adolescents. Staff will be identified using the policies and processes. letter A and their professional titles. This location will be identified as Strategic Behavioral Center-Garner in the report. V 105 V 105 27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY **POLICIES** (a) The governing body responsible for each

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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that area of service;

(E) strategies for improving client care;

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11/17/21

PRINTED: 11/02/2021 FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ C. B. WING 20140058 10/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WATERFIELD DRIVE STRATEGIC BEHAVIORAL CENTER-GARNER GARNER, NC 27529 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETE DATE **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 105 Continues V 105 Continued From page 2 V 105 (F) review of staff qualifications and a Measures that will be put in place to determination made to grant correct the deficient area of practice: 11/17/21 treatment/habilitation privileges: Education on the discharge process for (G) review of all fatalities of active clients who PRTF is being completed with all direct care were being served in area-operated or contracted staff. residential programs at the time of death: (H) adoption of standards that assure operational Education on the discharge process for 11/17/21 and programmatic performance meeting PRTF is being completed with all applicable standards of practice. For this physicians/ providers. purpose, "applicable standards of practice" means a level of competence established with RNs and therapists have been trained on 11/17/21 reference to the prevailing and accepted ensuring physicians are ordering all methods, and the degree of knowledge, skill and discharges and transfers to other levels of care exercised by other practitioners in the field; care. Education on documentation of medication orders has been completed with nursing 11/10/21 staff and providers/physicians. Review of the Restraint/ Seclusion policies and processes were reviewed by 11/17/21 Leadership. Re-education of restraint/ seclusion processes has been completed This Rule is not met as evidenced by: with all direct care staff. Based on record review and interview the facility failed to follow its discharge policy and failed to All direct care staff have been trained on all implement written standards that assured aspects of seclusion and restraint to include 11/17/21 operation and programmatic performance observations during and after interventions. meeting applicable standards of practice for restraint and seclusion orders along with Physician/ provider education has been monitoring of the client in and immediately after provided on restraint/ seclusion restraint, assessment post seclusion or restraint

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findings are:

policy revealed:

and meeting training requirements for a staff

involved in a seclusion and restraint incident. The

A. Review on 10/21/21 of the facility discharge

"Purpose- Discharge planning is an

organized, coordinated process, with

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documentation requirements including

quidelines for restraint/ seclusion orders.

Additional training on Restraint/ Seclusion, Roles and Responsibilities and Milieu

and responsibilities in codes, has been

assigned quarterly to all direct care staff.

Management, leadership roles, responding 11/17/21

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_ C. B. WING 20140058 10/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WATERFIELD DRIVE STRATEGIC BEHAVIORAL CENTER-GARNER GARNER, NC 27529 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETE DATE **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 105 Continued V 105 Continued From page 3 V 105 CPI refresher training will be completed with 11/17/21 multidisciplinary team, patient and family input, identifies the patient's needs after discharge, all direct care staff. delineates plans to meet these needs and Additional CPI training and use of deteaches the patient and family how to implement the plans. Discharge planning is an ongoing escalation techniques has been assigned to process which begins on admission and all direct care staff. continues throughout the patients hospitalization. The planning is continually assessed and One Hour Face to Face education has been 11/17/21 re-evaluated for appropriateness. reviewed and will be completed with RNs Policy-Possible referrals included are covering processes and documentation Medical/Physician/provider, professional ancillary requirements. resources, home health agencies, nursing homes, medical clinic, group homes, halfway Electronic documentation has been updated houses, and other hospitals or clergy services will with a Red Alert notification for the nurse be identified as needed, considering the ensuring a provider's order has been individual's cultural and ethnicity, in the discharge completed. plan. At the time of discharge, the licensed nurse completes the discharge instructions and Doctors and all providers have been given 10/26/21 summary" access to EHR remotely and can enter orders immediately. Review on 10/18/21 of Former Client (FC) #11 record revealed: All direct care staff received education on 10/15/21 Admitted: 7/7/21 the Code Brown policy and how to respond Discharged: 7/21/21 appropriately to the escalation of patient Diagnosis: Disruptive Mood behaviors. Dysregulation Disorder Age: 16 Education has been provided to House "Patient observation rounds" sheet dated Supervisors to ensure they understand that 11/5/21 7/17/21 listed "Resident was moved from 600 hall anyone in orientation or who are job to spend the night on 700 hall (Acute Unit) due to shadowing should not be counted in safety concerns on 600 hall. (Psychiatric staffing. Residential Treatment Facility-PRTF) "Patient observation rounds" sheets Measures put in place to prevent the dated 7/18/21- 7/19/21 FC#11 observation on problem from occurring again. 703-A HIM will audit all physicians and providers "Patient observation rounds" sheet dated orders. HIM will communicate with CMO/ 7/20/21 "Patient is on the hall for a short period of Medical Director when providers are not time. He is officially on hall 600." completing audited documentation and Daily Nursing Note dated 7/19/21 report findings in QAPI.

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revealed FC#11 "being programmed on another

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"It's all doctor driven, that would be weird

V 105 Ends

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	to move from PRTF to	o Acute for safety"				
		ine moving a client from				
	make sense"	ety reasons, that does not				
		rder required to admit or				
	discharge to the Acut					
	<ul> <li>Not aware o</li> <li>Acute Unit from the P</li> </ul>	fa client being moved to the				
	_	fFC#11 staying on the Acute				
		scharged from the PRTF				
	Below are examples	of where the following				
		gulations (CFR) were not				
	followed:					
	Review on 10/25/21 o	of facility Policy on Seclusion				
	and Restraint reveale	•				
	- Time limitati	ons: traint or seclusion has been				
		alified RN (Registered				
	•	a face to face assessment.				
	The RN shall inform					
	current condition. The	n/provider of the patient's e				
		n/provider will decide whether				
	or not to continue the restraint or seclusion "					
		o-face assessment and the				
		order must be documented cal record . The restraint or				
		the incident report shall be				
		volved in the emergency				
	safety intervention be This includes but is no	efore the end of the shift.				
		physical and psychological				
	status	1,3				
	The patient's					
	Least restriction to the restraint/seclus	ctive interventions used prior				
		riateness of the intervention				
	measures and					
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V 105	Continued From pag	e 6	V 105			
	intervention" - Implementa					
	physical managemer	ff trained in the use of nt must be physically present				
	restraint or seclusion					
	trained staff"	by a registered nurse and/or				
	observed in person b	patients are continuously by trained and competent				
		eted and maintained periodic				
	• .	ntinuous observations are				
		5 minutes. If staff are unable				
		nt, the door will be opened, in				
	order to fully assess t	the patient. Direct patient				
	care staff observation	ns in clude: an y signs of injury				
	or distress, patient's	behavior, hydration and				
	nutritional needs, ski	in integrity, signs of				
	exhaustion and indic	ators or readiness for				
	discontinuation of the	e restraint or seclusion and				
	recognize when to co	ontact a medically trained				
	license independent	<del>-</del>				
		esses the patient in restraint				
		cuments the assessment 15				
	minutes or more frequently as warranted by the patient's condition."					
	=	tion for Emergency Safety				
	Interventions:	ion for Emergency datety				
		techniques or seclusion will				
		registered nurse in the				
	patient's medical reco					
	•					
		entation and outcome of e behavior at time of release)				
	• •	e failure of less restraint or				
		tation must be completed by				
		n which the intervention				
		i willcii ule ilitervelluoli				
	occurs."	intorseclusion/Flowsheet				
		ation entry by the assigned				
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Division	of Health Service Regu	llation			1 Orav	
V 105	Continued From pag	e7	V 105			
V 105	staff at least every 15 the restraint or seclus patient must be conti is completed at initial thereafter and includ of restraint or seclusi "Signs of an applying restraint/sec  - Restraint or "When a pat he/she must be unde staff trained in the us situations. The staff in present immediately of continuously assessi evaluating the physic well-being of the patic B. Review on 10/25/2 for Seclusion or Rest or seclusion is verbal received by a registe staff such as a license emergency safety inte staff or immediately a situation ends. The p practioner permitted order restraint or sec order in a signed for  Review on 10/8/21 of - Admission of - Admission of - Byears old - Diagnoses: Dysregulation Disord Disorder/Adolescent Unspecified Mood Di	is minutes from initiation of sion and observation of the inuous. The RN assessment tion and every 15 minutes, es, as appropriate to the type on the following: y injury associated with clusion"  seclusion Guidelines: tient is in the seclusion room of constant observation of e of emergency safety members must be physically outside the seclusion room ing, monitoring, and cal and psychological ent in"  21 CFR-"§483.358(d) Order traint-If the order for restraint I, the verbal order must be red nurse or other licensed d practical nurse, while the ervention is being initiated by after the emergency safety hysician or other licensed by the state and the facility to lusion must verify the verbal min the resident's record"  folient #1's record revealed: date 5/17/21 d. Disruptive Mood der (DMDD), Conduct	V 105			
	(ODD)  OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
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Division	of Health Service Regu	lation			_	
	Continued From pag		V 105			
	2021 Medication Admirevealed:  - Medication I listed on 9/25/21  - No signature on 9/25/21  Interview on 10/18/21 Nursing Officer (CNC)  - Did not see: #1's chemical restrain	an order for 9/25/21 for client nt s signed off on the MAR for				
STATEMENT	Interview on 10/21/21  - Was a Registered - This was the in the facility - Was the nur the chemical restrain - Can't remen Nurse Practioner #1 ( - Administere injection - Didn't remer record who she receitime - Did not sign restraint given to clie  Interview on 10/20/21 - Was on call - Ordered me chemical restraint - Didn't remer that called - Didn't docur	the Nurse #1 reported: Nurse (RN) e 2nd day working on her own rese that called for approval for t for client #1 nber the time she called the (NP) ed Zyprexa and Benadryl mber writing in the client ved approval from or the the MAR for the chemical nt #1 the NP #1 reported: on 9/25/21 dications for client #1 for the mber the name of the nurse ment the call from the nurse	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	NIRVFY
	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , -	CONSTRUCTION	(X3) DATE S COMPL	ETED
		20140058	B. WING			2 <mark>6/2021</mark>
NAME OF P	ROVIDER OR SUPPLIER	STREET ADDR	RESS, CITY, STAT	TE, ZIP CODE		
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Division	of Health Service Regu	lation				
V 105	Continued From page	e 9	V 105			
	C. Review on 10/25/2	_				
	•	sident in and immediately				
	_	I staff trained in the use of				
	emergency safety into					
		ontinually assessing and				
	monitoring the physic					
	_	dent and the safe use of				
	restraint throughout t					
		ervention and CFR 483-358				
	(f) AssessmentpostS					
		ur of the initiation of the				
		ervention a physician, or				
		tioner trained in the use of				
		erventions and permitted by				
		lity to assess the physical				
		ell being of residents, must				
	conduct a face-to-fac					
		logical well being of the				
	resident, including bu					
		s physical and psychological				
	status;					
	(2) The resident					
	, ,	ateness of the intervention				
	measures; and					
		ation's resulting from the				
	intervention"					
	Review on 10/18/21 a	at 9:38 AM of video footage				
		the isolation room and 300				
		solation room from the				
	9/25/21 incident reve					
	approximate time fran					
	• •	lient#1 was in handcuffs and				
		n room by a Police Officer,				
	two other Officers in t					
		n Officer is seen looking into				
		7 PM and he holds the				
	isolation room doors					
	- 11:32 PM Ni	urse#1 and a staff from				
	another hall enter the	isolation room with				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		` ´COMPL	ETED
					,	
		20140058	B. WING		10/2	26/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS CITY STA	TE ZIP CODE		
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  3200 WATERFIELD DRIVE					
STRATEG	SIC BEHAVIORAL CENTE					
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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Division	of Health Service Regu	lation	ı	T	-	
V 105	Continued From page	e 10	V 105			
	the oral medication 11:41 PM N room 11:44 PM orestraint in each army on the floor, Officer in while staff outside the 11:54 PM ha Police as staff #3 arriattack the Police Officerived in the roomI Mental Health Techn with client #1 12:21 AM cli Review on 10/20/21 of Self-Debriefing Assess dated 9/25/21 reveale No informatic chemical restraint Review on 10/25/21 reveale No documer or physical aggressio No documer or physical aggressio No documer or physical restraint No documer chemical restraint No documer chemical restraint No documer in the isolation room No documer in the isolation room No documer client throughout her after being returned to night.  Interview on 10/18/21 reported: Should have	and cuffs removed by the ved, client #1 attempted to cers, then House Supervisor House Supervisor and Lead ician (MHT) #1 in the room lient #1 left the isolation room.  If the "Patient ment sheet" for client #1 ed: ion regarding the use of a lead: intation of unsafe behaviors on intation of a physical or intation of staff monitoring time in the isolation room or o her hall throughout the				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPL	
			A. BUILDING:			
		20140058	B. WING	<u> </u>	10/2	:6/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
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		GARNER,	ı		1	
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iviaion of Ha	alth Service Regulation		•	•		

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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 - 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 - Sometimes they go in the isolation room - Sometimes they go in the isolation room - Did not remember documenting her checks on client, #1 on 9/25/21 while she was in the isolation room you did did check on the several times - Staff were supposed to stay with the client while in the isolation room monitoring them through the door and other several times - Staff were supposed to stay with the client while in the isolation room monitoring them through the door and full did check on the 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 the rescond day of training and first day on the unit of the client #1 her medication after the Police handcuffed her - Client #4 was in the isolation room for - Interview on 10/18/21 the Nurse #2 stated: - 9/25/21 was the rescond day of training and first day on the unit in the isolation room monitoring them through the door - Lient #4 was in the isolation room for - Lient #4 was in the isolation room for - Lient #4 was in the isolation room for - Lient #4 was in the isolation room for - Lient #4 was the client #4 here the Police handcuffed her - Client #4 was in the isolation room	Division	of Health Service Regu	lation				
- 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 "cacill fifthe hurse 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 white in the isolation room - Sometimes they go white the room they have go the sometimes they go white the room they go white the room they go white they go wh	V 105	Continued From page	e 11	V 105			
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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 call mand if not they check through the door and ask the client if they needed anything  Did not remember do cumenting 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 hand coulfed her Client #4 was in the isolation room for  Statement or personal coulfed her Client #1 was in the isolation room for  Statement or personal coulfed her Client #1 was in the isolation room for  Statement or personal coulfed her Client #1 was in the isolation room for  Statement or personal coulfed her Client #1 was in the isolation room for  Statement or personal coulfed her Client #1 was in the isolation room for  Statement or personal coulfed her Countered Canner, No 27539  NAME OF PROVIDER OR SUPPLIER  STRATEGIC BEHAVIORAL CENTER-GARNER  ON ALL SUMMARY STATEMENT OF DEFICIENCIES SOUNT STATE ZIP CODE  320 WATERFIELD DRIVE CANNER, No 27539  ON ALL SUMMARY STATEMENT OF DEFICIENCIES DRY FULL PREPAYE (GACH DEFICIENCIES DRY FULL PREPAYE)  (GACH CORRECTION NUMBER E PRECEDED BY FULL PREPAYE)  (GACH CORRECTION CONTINUES DRY FULL PREPAYE)  (GACH CORRECTION CONTINUES DRY FULL PREPAYED TO THE APPROPRIATE DATE							
- 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') administered the chemical restrainto 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 clientwas 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 clientwhile 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  STATELENT OF EDFICIENCIES  AND PLAN OF CORRECTION  A BUILDING: - C		- On 9/25/21 t working alone - There were	his was her second day				
- 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  STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDERSUPPLERICLIA IDENTIFICATION NUMBER:  20140058  NAME OF PROVIDER OR SUPPLIER  STRATEGIC BEHAVIORAL CENTER-GARNER  AS UNING PROVIDER'S PLAN OF CORRECTION SHOULD BE COMPLETED DRIVE GACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR ISS. DESTRIPTION SHOULD BE COMPLETED DATE  TAG GROWATERFIELD DRIVE GROWER ACTION SHOULD BE COMPLETED DATE  TAG GROWATERFIELD DRIVE GROWER ACTION SHOULD BE COMPLETED DATE  TAG GROWATERFIELD DRIVE GROWER ACTION SHOULD BE COMPLETE DATE  TAG GROWATERFIELD DRIVE GROWER ACTION SHOULD BE COMPLETE DATE  TAG GROWATERFIELD DRIVE GROWER ACTION SHOULD BE COMPLETE DATE  TAG GROWATERFIELD DRIVE GROWER ACTION SHOULD BE COMPLETE DATE  TAG GROWATERFIELD DRIVE GROWER ACTION SHOULD BE COMPLETE DATE		- Staff #2 was stayed out at the nurs	se's station				
15 minutes while in the isolation room		- She (nurse restraint to client #1	1) administered the chemical				
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  STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER STREET ADDRESS, CITY, STATE, ZIP CODE  3200 WATERFIELD DRIVE  STRATEGIC BEHAVIORAL CENTER-GARNER  (X2) ID PREFIX GRAND RY STATEMENT OF DEFICIENCIES GARNER, NC 27529  DPREFIX TAG  REGULATORY OR USE PRECEDED BY FULL PREFIX TAG  REGULATORY OR USE DEATH FYING INFORMATION)  TAG  REGULATORY OR USE PRECEDED BY FULL PREFIX TAG  REGULATORY OR USE DEATH FYING INFORMATION)  AT DATE  TAG  REGULATORY OR USE DEATH FYING INFORMATION)		15 minutes while in the Sometimes to if the client was calm	ne isolation room they go in the isolation room and if not they check				
- 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 hand cuffed her - Client #1 was in the isolation room for  STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  MAME OF PROVIDER OR SUPPLIER  STRATE ADDRESS, CITY, STATE, ZIP CODE  STRATEGIC BEHAVIORAL CENTER-GARNER  STREET ADDRESS, CITY, STATE, ZIP CODE  STRATEGIC BEHAVIORAL CENTER-GARNER  GARNER, NC 27529   (X3) DATE SURVEY COMPLETED  C 10/26/2021  PREFIX GARNER, NC 27529		- Did not reme checks on client #1 o the isolation room, bu	n 9/25/21 while she was in				
- 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  STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  A. BUILDING:  B. WING  CC  10/26/2021  NAME OF PROVIDER OR SUPPLIER  STRATEGIC BEHAVIORAL CENTER-GARNER  (X4) ID  PREFIX  GARNER, NC 27529  (X5)  PREFIX  TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX  TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX  TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  AMULTIPLE CONSTRUCTION  (X2) MULTIPLE CONSTRUCTION  (X3) DATE SURVEY  COMPLETE  DATE  CR  (X4) ID  PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE COMPLETE  DATE		- Staff were s client while in the iso					
the Police hand cuffed her Client #1 was in the isolation room for  STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING: C C SUMMARY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X3) DATE SURVEY COMPLETED  (X4) ID PREFIX FRET ADDRESS, CITY, STATE, ZIP CODE  3200 WATERFIELD DRIVE GARNER, NC 27529  (X4) ID PREFIX CEACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE  DATE		- 9/25/21 was her second day of training and first day on the unit					
AND PLAN OF CORRECTION    IDENTIFICATION NUMBER:   A. BUILDING:   COMPLETED		the Police hand cuffe	d her			_	
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	about an hour, it took down	a long time for her to calm				
	- They did ch nurse documented th	eck on her, but the other is				
	Interview on 10/21/21 stated:	the Police Officer #1				
	- Responded on 9/25/21.	to an incident at the facility				
		s aggressively kicking the ear a broken window				
	<ul> <li>Told her to see</li> </ul>	stop or he would put her in				
	- Client#1 sai	id, "put me in cuffs"				
		ime, no staff was immediately				
		staff in the nursing station				
		d client #1 in hand cuffs due to				
	her continuing to kick					
		aff for a place to put client #1				
	<ul> <li>A male staff</li> </ul>	(House Supervisor) came in				
	and told him to place	her in a room that had				
	padded walls (isolation	on room)				
	<ul> <li>The door to</li> </ul>	this room did not lock so				
		o stand by the door with his				
		eep her from getting out as				
	she was still continui	<del>-</del>				
		was holding his foot on the				
	door so she was not	•				
		aff was moving around the				
		ee staff stand by the door				
		ne staff was just walking				
	around"					
		ck to the hallway and another				
	Officer (Police Officer	-				
	-	taff #1) stayed at the end of				
	the hall and talked to					
	plan to sedate the [cli	e, the staff came up with a				
	-	isolation room client #1				
QTATE MEN T	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIPI E	CONSTRUCTION	(X3) DATE S	HIDVEV
	OF CORRECTION	IDENTIFICATION NUMBER:	, ,	- donormounion	COMPL	
			A. BOILBING.			
		20140058	B. WING		10/2	26/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STAT	TE, ZIP CODE		
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(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
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				DEFICIENCY)		

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V 105	Continued From page	e 13	V 105			
V 105	remained in handcuff  - After client # the Police Officer #2 ther they would remove remained calm  - During this to of the isolation room, checking client #1's with a concept of the Officers  - Once they go removed the handcut of the Officers  - Client #1 put Officer #2 who was in a concept of the Officer with a concept of the Officer of the Officer of the Officer with a concept of the Interview on 10/21/21 stated:	fs  #1 received her medication, tried to talk to her informing we the handcuffs if she  ime, "the nurse was in and out "but not sure if she was ritals. ot client #1 to stand and ffs, client #1 assaulted one shed forward toward Police of the doorway er #2 stood in front of another of #1, but she pushed, hit and or back in the isolation room told her to calm down but ck and scratch him er #2 pushed her back in the er #2 had to use "force-the as used to keep her from collation room the "arm bar technique" time, the staff started to come as around the door at the time and two male staff were right en came into the isolation out intervene"	V 105			
	spoke with the Police	y, but heard the call and Officer #1 and could tell the				
	situation was "hostile	and he asked him to come				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE S COMPL	
						:
		20140058	B. WING			6/2021
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETE DATE

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V 105	Continued From pag	e 14	V 105			
	help them out					
	· ·	e facility around 11:30-11:45				
	PM					
		were verbally "hostile"				
		n the scene told him they had				
		ding cell" (isolation room)				
	who was "irate and h					
		the hall and talked to client				
		om and she kept asking to				
	take the handcuffs of					
	<ul> <li>Told her the</li> </ul>	ere was a reason she was in				
	them					
	<ul> <li>Staff then br</li> </ul>	oughtin a shot and she was				
	ok with the shot and	asking for it				
	<ul> <li>One staff (N</li> </ul>	urse #2) said she was a new				
	"contractor" (contrac	•				
		r 1st or 2nd night working				
		n know what is going on"				
		he staff trying to control client				
	#1 while he was pres					
		as observing client #1 in the				
		saw Nurse #2 come in and				
	· ·	were the ones handling				
	client#1					
		as sitting on the floor				
		ther staff members around				
	- Then a nurs	se came to give client #1 a				
	second shot					
	<ul> <li>1st shot in le</li> </ul>	eft arm and client#1 was "ok"				
	<ul> <li>Took the ha</li> </ul>	ndcuffs off and she walked				
	out to the main hall					
	<ul> <li>Another Offi</li> </ul>	icer was standing in the door				
	and client #1 hit the C	Officer in his back				
	<ul> <li>An Officer th</li> </ul>	nen tried to grab her hand and				
	she swung at him					
		oped in and she swung at him				
	saying, "get the f***k					
		to block her hand and "put				
	her in an arm bar"	to block her hand and par				
		nat staff was doing, I was too				
			()(0) 1444 7194 5		T	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE S	
74451544	or contraction	IDENTIFICATION NOMBER.	A. BUILDING:		O O MIT E	
					(	;
		20140058	B. WING		10/2	6/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STAT	TE. ZIP CODE		
	3200 WATERFIELD DRIVE					
STRATEG	IC BEHAVIORAL CENTE			_		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX	<b>Y</b>	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI		COMPLETE DATE
TAG	REGULATURY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	MIE	DATE
				<u>'</u>		

Division of Health Service Regulation

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Division	of Health Service Regu	lation				
V 105	Continued From pag	e 15	V 105			
	busy blocking punch	es"				
		1 back in the room with "a				
	wrist lock on her face	go, she then jumped at him				
	and kicked him twice					
		‡1 to back up, she tried to get				
		swung and hit him in the				
	shoulder					
		ed to swing again, then ne wall "with my elbow in her				
	sternum against the					
	_	ached with her other hand				
	and tried to scratch a					
		ame in 30-40 seconds later,				
	just saying client #1's	s name over and over nales and one female staff				
		ation room and said they got				
	her.					
	· ·	y, where the h**l y'all been"				
		ero control, I have seen more				
	control with 5th grade - "It was a d**	er on 5th grader supervision"				
		p to the clean up because				
	they (staff) were drov					
		in the middle of a facility,				
	=	tc. with no staff trying to do				
	anything during that I					
	·	taff #1) had a good rapport rest were just bumps on a				
	log"	est were just bumps on a				
		on, they (staff) should have a				
	· · ·	) a*s, not me to have to				
	control this situation	' iff (Nurse #2) seemed "over				
		ner staff was "completely				
		us (Police Officers) to do				
	their job for them"					
	Interview on 10/21/21 (CMO) stated:	the Chief Medical Officer				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIPI F	CONSTRUCTION	(X3) DATE S	NIDVEV
	OF CORRECTION	IDENTIFICATION NUMBER:	,	- CONCINCOTION	COMPL	
					,	
		20140058	B. WING			26/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STAT	re, zip code		
		3200 WATI	RFIELD DRIV			
STRATEG	IC BEHAVIORAL CENTE	ER-GARNER GARNER,	NC 27529			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI		DATE
				DEFICIENCY)		

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Division	of Health Service Regu	ılation			1 0141	17(1110125
V 105	Continued From pag	e 16	V 105			
	Continued From pag  - Was just ma 9/25/21 yesterday (10  - Been provio treatment for 21 years  - "Police show can not come on to a it's illegal."  - Staff should and contacted the do  Interview on 10/18/21 of Quality Compliance stated:  - Was on vacc occurred on 9/25/21  - The situation have led to the Police - When a clief staff were to observe the door  - While watch the 300 hall, not sure monitoring client #1 w  - Clients show while in the isolation  Interview on 10/25/21 stated:  - He had beer Prevention Interventi  - Training wa psychiatric hospital	de aware of the incident on 0/20/21) from a colleague ding services in Psychiatric suld not be in a hospital, they unit and restrain someone, and have handled the situation octor and 10/26/21 the Director de and Risk Management ation during the incident that an "spiraled" and should not de being called ant is in the isolation room, the other client at the window of a why staff were not present while in the isolation room and have constant monitoring room.  If the Program Coordinator and the trainer for Crisis ions (CPI) for the staff is very clear that they were	V 105			
		keep the clients safe and owhen the staff "were not				
	equipped to do so"	had been "reluctant" in the			ļ	
	past to use their train				ļ	
	and to intervene	as escalating, the doctor				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	, ,		COMPL	
		20140058	B. WING		40/0	
NAME OF B	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE ZID CODE	10/2	26/2021
		3200 WATI	ERFIELD DRIV			
SIKALEG	IC BEHAVIORAL CENTE	GARNER,	NC 27529			ı
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETE DATE
	alth Camina Danilatian			1		1

Division of Health Service Regulation

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TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	41E	DATE
(X4) ID PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE DATE
(V/) ID	SLIMMARV ST	GARNER,  ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	j l	(X5)
STRATEG	IC BEHAVIORAL CENTE	R-GARNER	RFIELD DRIV	E		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STAT	TE, ZIP CODE		
		20140058	B. WING		_	6/2021
					C	;
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPL	
071	respond	()() 220/4255 (200-200-200-200-200-200-200-200-200-200	(VO) 1411 770	CONCERNATION	()(0) = :==	UD) (5) (
	<ul> <li>Not aware th</li> </ul>	nat many Police had to				
	with the verbal escala	rse's station and not dealt ation going on				
		about how several staff just				
		od job during the incident				
	- The staff wh	o were involved that evening				
	done differently					
		ne video with the starr ne what could have been				
	had been resolved	ne video with the staff				
		in thirty minutes and things				
		s were "pretty heightened"				
	<ul> <li>The staff we</li> <li>Never "Ok" y</li> </ul>	with the Police being called				
	attacked and jumped					
		old her the clients on 300 hall				
		Supervisor called her a little				
	the 300 hall	ien ure meident occurred on				
		Administrator On Call (AOC) en the incident occurred on				
	Interview on 10/25/21					
	interventions date: Ex	alternatives to restrictive prired 3/12/21				
	- Hire date of					
		of staff #1's record revealed:				
	uns secuon on an am	iluai basis				
	competencies as spe this section on an an	ecified in paragraph (b) of				
		emiannual basis and their				
		s specified in paragraph (a)				
		ng-) "Staff must demonstrate				
	D. Review on 10/25/2	11 of CFR§ 483.376 (f)				
	the correct amount of	f staff on duty				
		handled by staff if they had				
		ave contacted the Police as				
	behavior					
	should have been co	ntacted regarding the client's				
V 105	Continued From page	e 17	V 105			
DIVISION	or Hearth Service Regu	iialion	1	Т		

Division of Health Service Regulation

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Division	of Health Service Regu	lation				
V 105	Continued From pag	e 18				
V 103	- The staff did as they were trained - After the ince that evening were an being harmed by the - Was not away employee shadowing other staff - Staff #2 had to Restrictive Interver have shadowed and helping deescalate the - While client should have been in the staff - The client shafter the isolation by throughout the night.  This deficiency is cross NCAC 27G .1901 Sco	I not respond to the situation to do so ident heard that staff working xious and concerned about girls are there was a new githat evening alone with one been trained in Alternatives nations by the time she would should have engaged in the situation #1 was in isolation, she constant observation from the nould have been monitored the nurse and ongoing				
V 109	27G .0203 Privileging	g/Training Professionals				
	10A NCAC 27G .0203 QUALIFIED PROFES ASSOCIATE PROFE (a) There shall be not qualified professional (b) Qualified professional shall do and abilities required (c) At such time as a employment system ithen qualified professionals shall do (d) Competence shall do (d) Compet	COMPETENCIES OF SSIONALS AND SSIONALS o privileging requirements for is or associate professionals. Sionals and associate emonstrate knowledge, skills by the population served. It competency-based is established by rulemaking, sionals and associate emonstrate competence.		Measures put in place to correct deficient area of practice:  Additional training and education Governing Board Oversight and E Leadership has been completed b CEO.	on xecutive y the	11/15/21
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE S COMPL	
		20140058				26/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADDR	RESS, CITY, STAT	TE, ZIP CODE		
STRATEG	IC BEHAVIORAL CENTE		RFIELD DRIV	/E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETE DATE

Division of Health Service Regulation

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Division of Health Service Regulation 11-10-21 CEO, QIRM, CNO, and DCS have Continued From page 19 V 109 registered for NC DHSR MHLS: Provider exhibiting core skills including: training in Raleigh. (1) technical knowledge; (2) cultural awareness; Weekly mentoring and coaching with the 11-13-21 (3) analytical skills; CEO has been scheduled with a seasoned (4) decision-making; CEO from a sister facility. First mentoring (5) interpersonal skills; session has been completed. (6) communication skills: and (7) clinical skills. CEO completed and reviewed the 11-13-21 (e) Qualified professionals as specified in 10 A Orientation and competency checklist with NCAC 27G .0104 (18)(a) are deemed to have CEO at sister facility. met the requirements of the competency-based employment system in the State Plan for Measures put in place to prevent the MH/DD/SAS. problem from occurring again. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision Documentation from the weekly coaching plan upon hiring each associate professional. will be forwarded to the CEO's supervisor (g) The associate professional shall be for evaluation of duties. supervised by a qualified professional with the population served for the period of time as CEO will maintain continuing education specified in Rule .0104 of this Subchapter. 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, This Rule is not met as evidenced by: Governing Body and Oversight of the Based on record review, observation and hospital, polices procedures, and Quality interview the facility failed to ensure one of two Indicators and outcomes. audited Qualified Professionals (Chief Executive Officer (CEO)) demonstrated knowledge, skills How often will the monitoring take place and abilities required by the population served. and by whom: The findings are: CEO's Supervisor Review on 10/25/21 of the CEO's record Mentor CEO revealed: Weekly Hire date of 4/19/21 Monthly Received a Master's Degree in Education Yearly (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A. BUILDING: \_\_\_ С B. WING 20140058 10/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WATERFIELD DRIVE STRATEGIC BEHAVIORAL CENTER-GARNER GARNER, NC 27529 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) ivision of Health Service Regulation

Division	<u>of Health Service Regu</u>	ılation				
	Continued From page		V 109			
	·	tion/jobduties revealed:				
		Executive Officer (CEO) is				
	accountable for admi	nistering, directing and				
	coordinating through	the executive team of				
	operations of the beh	navioral health system. The				
	CEO remains current	t with changing industry				
	conditions, accreditat	tion/licensing requirements,				
	contemporary analyt	ics and market				
	requirements The C	CEO, alongside the Board,				
		hip, champions quality				
	patient care in suppo	ort of positive clinical				
	outcomes. CEO assu	umes full operational				
	oversight of the facili	ty. The CEO will actively				
	facilitate strategic pla	anning and corresponding				
	development activitie	es including but not limited to:				
		ty outreach, human resource				
	management, patient	t services, payer contracting,				
	medical/psychiatric re					
		uality improvement. This				
		udent decision making,				
	initiative, judgment, p					
		a multitude of situations."				
	3					
	Below are examples t	the CEO did not				
	demonstrate compete					
	'	,				
	A. Refer to V105 examp	ple A regarding Former				
		noved to a different level of				
	· · · · · ·	thorization or approval.				
		on included the following				
	information:	3				
	-Between 7/17/2	1 and 7/20/21 FC#11 was				
	programmed during t	the day on his assigned 600				
		dical and housing during				
		g overnight observations on				
	_	hall was licensed for clients				
		igher level of care. This type				
		s the Acute unit. On 7/21/21,				
	FC#11 was admitted					
	-FC#11's record	revealed no physician's				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	, ,		COMPL	
						_
		20140058	B. WING		10/2	2 <b>6/2021</b>
			1		10/2	10/2021
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA			
STRATEG	IC BEHAVIORAL CENTE	R-GARNER	ERFIELD DRIV	/E		
		GARNER,	NC 27529			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI		COMPLETE DATE
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division of the	alth Camira Danidatia		I	l .		

Division of Health Service Regulation

Division	of Health Service Regu	lation			_	
V 109	Continued From pag	e 21	V 109			
	Continued From page order, guardian constreassignment of FC#  -The Chief Nursi the move between acceptance (Psychiatric Resident have been considered have only occurred if was "too acute" for the Parents consent would be to the Acute Hall, the that day before they to "It's all docted to move from PRTF to safety."  - "I can't image PRTF to Acute Hall for not make sense."	ent for the 7/17/21-7/20/21  11  ng Officer (CNO) reported sute unit and PRTF  tial Treatment Facility) would set a discharge and would set a physician felt the client e PRTF to meet his needs.  Ild be required.  In the CEO stated: Int moved from the PRTF Hall discharge was completed ransfer to the Acute Unit.  For driven, that would be weird to Acute Unit (hall) for the moving a client from reafety reasons, that does	V 109			
		e Unit Unit. fa client being moved to the				
	Acute Hall from the P	<del>-</del>				
		scharged from the PRTF				
STATEMENT	Compliance and Risk  - Was made a from the PRTF to the discharged during the - "Flash meeti morning with all depa meeting, attendees d across the hospital - It was repor there were concerns regarding FC#11's me	the Director of Quality  k Management stated: ware of FC#11 being moved Acute Hall without being eir morning "flash meetings" ings" were held every artment heads. During the iscussed what was going on ted from the court liaison from the Special Counsel ove to Acute Unit Unit neeting the CEO called the	(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE S	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	COMPL	
		20140058	B. WING		10/2	26/ <b>2021</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET ADDR	RESS, CITY, STAT	TE, ZIP CODE		
STRATEG	IC BEHAVIORAL CENTE		RFIELD DRIV NC 27529	/E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETE DATE

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Division	of Health Service Regu	ılation				
V 109	Continued From pag	e 22	V 109			
	Continued From page House Supervisor and the issue had been received an issue regarding Fill Hall and that the CEO or The House Director of Quality Common Management) that shover the weekend be Administrator on Cal "ok" for FC#11 to mosafety.  She had sp Referral Manager (A& the status on FC #11 or The A&R Mark a hard time getting the status on FC #11 or The doctor paperwork and he had not officially discharge another.  "Even if you move until you get the light of the CEO for guidance or the A&R Mark the CEO told her to be another night.  After finding a conversation with the center of the center	d stated to the group that esolved ay she learned there was still C#11 still being on the Acute O was aware of it. Supervisor told her (the ompliance and Risk he had contacted the CEO cause the CEO was the I (AOC) and she gave the ve to the Acute Hall for oken to the Admission and BR) to get an update about . mager stated she was having he guardian's consent. was supposed to do the ad not, therefore she could ge FC#11 from one unit to  aget a doctor order you can't e guardian consent." e A&R Manager to go to the in this issue anager went to the CEO and et him stay on the Acute Hall gout this information, she had he CEO about it.	V 109			
	[CEO]'s office to add					
		aid "I know you don't like it at me to do, it's already			ļ	
	done."	•			ļ	
		nversation, she contacted ce to let her know and she			ļ	
	said she would hand				ļ	
		any attorney had reached out ek to check on the situation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	, ,		COMPL	
		20140058	B. WING		10/2	2 <mark>6/2021</mark>
NAME OF P	ROVIDER OR SUPPLIER	STREET ADDA	RESS, CITY, STAT	TE, ZIP CODE		
STRATEG	IC BEHAVIORAL CENTE		RFIELD DRIV NC 27529	E		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETE DATE

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NAME OF P	ROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STAT	FE, ZIP CODE		
		20140058			10/2	16/2021
		20140058	B. WING		10/2	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	EIED
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	, ,	CONSTRUCTION	(X3) DATE S	
		ose piercing in the 8 years				
	- Clients had	not been permitted to wear				
	Review reported:	are Bricotor of Guilzauon				
	Interview on 10/20/21	the Director of Utilization				
	chemis using the Sam	e grae or preionig				
	<ul> <li>Concerned a clients using the sam</li> </ul>	about hygiene issues with the				
	use.	ah a daharatan atau 20.0				
	<del>-</del>	usually have those items to				
	have the items.					
	- They told he	er the CEO allowed them to				
	piercing (stud).					
		d client#1 had a nose				
		wed up in her class today with				
	Interview on 10/20/21	a Teacher stated:				
	client#1 had a nose p	preiding				
		id on fake eyelashes and				
		/20/21 at 2:00 PM several				
	-					
	type of management					
	-	ectively" do her job under this				
	- Had resigne day will be 10/28/21	ed her position and her last				
	management.	ad bonno olition and bon to t				
	entire hospital for cor	mpliance and risk				
		oblem" as she is over the				
	throughout the entire					
		O and CEO remained				
	the "flash meeting."	acca irom arc remainaci oi				
		second or third person to used from the remainder of				
	from the meeting.	account or third person to				
	·	artment and then excused				
		tative presented what				
		flash meetings" each				
	meetings" were then	_				
		uation, morning "flash				
	regarding the matter.					
	as he was informed fr	rom the corporate office				
V 109	Continued From page	e 23	V 109			
	or nearm Service Regu					

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Division	<u>of Health Service Regu</u>	lation				
V 109	Continued From pag	e 24	V 109			
	she had worked there	Э.				
		d the CEO allowed the clients				
	to go into the contrab	<del>-</del>				
	_	ose piercing and allowed				
	them to wear those it	=:::=:				
		k the nose piercing and the				
		opriate for this type of setting t it was "unsanitary."				
	Interview on 10/26/21	staff #6 stated:			ļ	
	<ul> <li>Noticed the</li> </ul>	clients on the 300 hall had				
	_	lient with a nose piercing a				
	few weeks ago					
		a lead Mental Health				
	` ,	at the CEO took some of the and closet to retrieve those				
	items.	and closel to retrieve those				
		re "shocked" she allowed				
	them to do this	TO STOCKED STOCKED				
		were walking around with				
	fake eyelashes on an	d a nose piercing, "All they				
	needed to do was go	to the club."				
		asion a client was				
		er eyes hurting her from				
	wearing the eyelashe					
		ed the eyelashes and she				
	was not sure what wa	as used to apply the				
	eyelashes.					
	Interview on 10/26/21	the Director of Quality				
		«Management stated:				
		a staff that the CEO took the				
	clients to the "bin" roo	om to get some items and				
	they were allowed to					
		ey were using "gorilla snot"				
	hair gel to apply the e					
		rned about this and went to				
	around the eye area	t the safety of using hair gel				
		ld her the hair gel would not				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	LECONSTRUCTION	(X3) DATE S	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	, ,		COMPL	
					<b>,</b>	
		20140058	B. WING		10/2	26/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
			RFIELD DRIV	Æ		
STRATEG	IC BEHAVIORAL CENTE	R-GARNER GARNER,	NC 27529			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI		COMPLETE DATE
		, 		DEFICIENCY)		

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Division	<u>of Health Service Regu</u>	ılation				
V 109	Continued From pag	e 25	V 109			
	be near their eyes.					
		ncerned as the eyelashes				
		eye lid and the hair gel				
	would run into their e	-				
		nown in her three years of				
	those type of items	ients being allowed to have				
		rned that client #1 was				
	-	e piercing in for safety reason				
		have been assessed by the				
	doctor to determine t	he level of safety and				
	observation as to what	at should be allowed with				
	these items.					
		the Chief Medical Officer				
	(CMO) stated: - Was not awa	are of clients having fake				
	eyelashes or nose pi					
	- "This is con	cerning, as who let it				
	happened"					
		dvise this to the clients				
	unless they were ass - "This is a ho					
		should have been assessed				
		ysician, nurse and therapist				
		lients to have those items.				
		not have been a "blanket				
	decision."					
	10/05/04	050				
	Interview on 10/25/21 - They held a	"spa day" a few days ago.				
		to go buy some face mask				
		vard the girls on hall 300				
		fany client having a nose				
	piercing					
		they had eyelashes				
		at was from their spa day				
		ey were using "gorilla spit"				
	hair gel to apply them - The clients h	n have hair gel in their hygiene				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					(	
		20140058	B. WING		10/2	26/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
STRATEG	IC BEHAVIORAL CENTE		ERFIELD DRIV NC 27529	Æ		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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.,.5		,	1,15	DEFICIENCY)		
distinction of the	alth Camina Danidation		-	•		-

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V 109	Continued From page	e 26	V 109			
	bins					
	- Didn't think	this was a problem for them				
	to have the eyelashes	s				
	0.00.00					
		21 of the North Carolina				
	Client#1 revealed:	nprovement System for				
		curred on 9/25/21				
		mmary: "Restrictive				
		er 09/28/2021 Patient was				
	agitated, uncooperati	ive, belligerent, irritable, and				
	wanted to fight/destr	oy property per the restraint				
	documentation. Patie					
		vior, violent behavior				
		assault, patient assault.				
		ed to prevent causing further				
		ners and to prevent her from perty. Patient was banging on				
		Police were called to help get				
		tient fought the police and				
	·	ing on doors and windows.				
		n to help calm patient,				
		documentation patient was				
	administered a chem	ical restraint."				
		of the Facility Incident Report				
	for client #1 revealed					
	_	dent date: 9/25/21				
		unable to control the situation,				
		alled to permit police back d to back up staff because				
		to control residents' unsafe				
		ce presences, patient [client				
		olice handcuff because she				
		ng the unit door to go out of				
	the hall. Patient told p	police "I will kick until police				
	_	er police prompted her				
		not stop, she was placed on				
		the quiet room. After police				
OTATEMENT		refused to stay in the quiet	(V2) MULTIPLE	CONSTRUCTION	(VO) DATE 0	I I D V (E) (
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPL	
			A. DOILDING.			
		20140058	B. WING		10/2	: :6/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STAT	E, ZIP CODE	-	
		3200 WATE	RFIELD DRIV			
STRATEG	IC BEHAVIORAL CENTE	ER-GARNER GARNER,	NC 27529			
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(X4) ID		GARNER, ATEMENT OF DEFICIENCIES	NC 27529	PROVIDER'S PLAN OF CORRECTION		(X5)
	ROVIDER OR SUPPLIER	3200 WATE	RESS, CITY, STAT			
NAME OF P	PROVIDER OR SUPPLIER	20140058 STREET AND			10/2	6/2021
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	(X3) DATE S COMPL	ETED
V 109	Continued From page room when she asked preventing her from gand punching police. until they were able to process, writer police talking to patient to called the series of the time frame of incitated and the series of the time frame of incitated and the series of the time frame of incitated and the series of the time frame of incitated and the series of the series	d to stay. When police were going out, she started kicking Resident wrestle with police of hold her. During the et allow him to continue alm down." pleted by House Supervisor at 10:30 AM of video footage dent on the 300 hall revealed ident from 9:15 PM until t#1 was removed from the sturned to her room.  The House Supervisor alle was called on hall 300 of tget control of the hall diministrator. On Call (AOC) 9/25/21 was the CEO eto that all resources had atted she was okay with him atted the CEO stated: eto AOC on call on 9/25/21 curred on the 300 hall supervisor called her a little old her the girls unit was mping on staff were attacking staff and staff. Supervisor stated he had lice when he called her Supervisor had used the swhen the staff is giving the olice during a riot. dutilized all other options elice.	` '	CONSTRUCTION		
	or Hearth Service Regu		.,,,,,			

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V 109	Continued From page 28	V 109		
	- 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			
	<ul> <li>Did not review the video of the incident on 9/25/21 until 10/4/21</li> </ul>			
	011 9/23/21 dittii 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			
	<ul> <li>Had since reviewed the video and felt the</li> </ul>			
	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"			
	<ul> <li>The CEO told her she was called by the House Supervisor that evening saying there was</li> </ul>			
	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			
	<ul> <li>This type of peer on peer conflict</li> </ul>			
	is"typical" behaviorin 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.			
	<ul> <li>The Police should not have been called in this situation.</li> </ul>			
	iii tiiis situatioii.			
	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.			
	<ul> <li>From what he was told, this was a behavior of one client.</li> </ul>			
	- Police should never be called to a			
STATEMENT	0F DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION (X3) DA	E SURVEY
	OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING:		MPLETED
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(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
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3200 WATERFIELD DRIVE STRATEGIC BEHAVIORAL CENTER-GARNER											
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE											
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AND FLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED							
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE S							
	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: 10 A NCAC 27G .1901 Scope (V314) for a Type A1 rule violation and must be corrected within 23 days.										
	- 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										
V 109	can not come on the because it's illegal."  - "I have been therapy does not work that does not work."	hould be contacted. Id not be at a hospital, they unit and restrain someone I doing this for 21 years, if rk, you don't call the Police,	V 109								
	Cantinual Frances		V 109								

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				APPROPRIATE DEFICIENCY)		
V 113	Continued From page	e 30	V 113	V 113 Begins		
V 113	27G .0206 Client Records		V 113	Measures that will be put in pl correct the deficient area of pi		
	individual admitted to contain, but need not (1) an identification fa (A) name (last, first, m (B) client record num (C) date of birth; (D) race, gender and (E) admission date; (F) discharge date; (2) documentation of developmental disabidiagnosis coded acco (3) documentation of assessment; (4) treatment/habilitat	all be maintained for each the facility, which shall be limited to: ace sheet which includes: niddle, maiden); ber; marital status;  mental illness, lities or substance abuse ording to DSM IV; Ithe screening and		Process for communication of a patient infection or medical concomow being completed in the EHI this form is initiated by the nurse form with patient concerns is routhe provider for review.  Education has been completed nursing staff regarding appropria of orders.  Education has been completed physicians/ providers regarding appropriate entry of orders.  A standardized process and for completion by the PRTF provider consulting physician/ provider is	ny cerns is R. Once e, the uted to with the ate entry with the	11/17/21 11/17/21
	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			developed to improve communic consulting care provided to incluinstructions for patient care folloreturn to PRTF.  Education on the standardized Consultation process will be conwith nursing and physician/provistaff.  Measures that will be put in phyrevent the problem from occagain:	cation of ude wup on mpleted vider	11/17/21
	of Diseases (ICD-9-C (B) medication orders (C) orders and copies (D) documentation of administration errors	:M); s; s of lab tests; and		Infection/ medical concerns documentation and reporting wil reviewed weekly by the Infectior Nurse. IC RN will report to the Creport of concerns for follow up physician/ provider within 24 hor	ll be n Control CNO any on by the	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STATE. ZIP CODE 3200 WATERFIELD DRIVE STRATEGIC BEHAVIORAL CENTER-GARNER GARNER, NC 27529 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PRFFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 113 Continued V 113 V 113 Continued From page 31 Physician/ provider not addressing relative to AIDS or related conditions is disclosed infection/ medical concerns timely will only in accordance with the communicable receive follow up with the CMO or Medical disease laws as specified in G.S. 130A-143. 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. This Rule is not met as evidenced by: Staff not completing trainings will not be Based on record review and interview the facility placed on the schedule. failed to maintain documentation of services provided for one of two audited Former Clients Who will monitor the situation to ensure (FC#10). The findings are: it will not occur again: CEO Review on 10/18/21 of FC#10's record revealed: CNO Admitted 4/21/21 and discharged 9/29/21 Infection Control Diagnoses of Disruptive Mood CMO Dysregulation Disorder, Major Depressive Medical Director Disorder, Trauma & Post Traumatic Stress Disorder How often the monitoring will take place  $_{11/17/21}$ - Age: 14 Daily/ Weekly/ Monthly Monitoring as indicated. Review on 10/20/21 of the Daily Nursing Notes for FC#10 revealed: "7/16/21: complained of abdominal pain ...Tylenol given" V113 Ends "7/17/21: complained of burning sensation during urination ...urine frequency. Medical consult placed to follow up ...call to quardian 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: STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_ B WING 20140058 10/26/2021

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NAME OF PROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STAT	E, ZIP CODE			
STDATEG	IC BEHAVIORAL CENTE	D CADNED	3200 WATE	RFIELD DRIV	E		
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V 113	Continued From pag	e 32		V 113			
V113	Reason for 0 and UTI (Urinary Trace of Send pt (passuspected genital heareas"  Signed by Pound on No document the primary physician Interview on 10/25/21 (CNO) reported: The staff that appointments, would back from the outside Registered Nurse (RNoor of the RNs en information was placeous of She would for the documentation was recommended and the survey date of 10/26/21 and the survey date of 10/26/21 and the recommended in FC#10 was provider, the information was placeous of the 7/17/21 referration the 7/17/21 referration the 7/17/21 referration the 7/17/21 referration for the recommended in FC#10's recommended i	Consultation: possible Fot Infection) stient) to get PCR testin rpes recurrent rash and hysician Assistant (PA) ntation of the follow up to 's office  the Chief Nursing Office  It transported the client bring the documentation provider and give to the N) sured the medical ed in the clients' records follow up to see if any ecceived from FC#10's Justice was not received by the exist vas not received by the exist exist vas not received by the exist the PA reported: ecceive any information the sides seen by the outside tion should have been cord  the Chief Executive Off insported clients to the a packet to be completed.	g for itchy visit to cer to the on ne s uly exit based	V113			
	- The nurses	ensured the medical					
	information was plac	ed in the clients' records	3				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CL		` '	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBI	ER:	A. BUILDING:		COMPLE	ETED
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		20140058		B. WING		10/2	6/2021

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STATE. ZIP CODE 3200 WATERFIELD DRIVE STRATEGIC BEHAVIORAL CENTER-GARNER GARNER, NC 27529 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** PRFFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 118 Beains V 118 27G .0209 (C) Medication Requirements Measures that will be put in place to correct the deficient area of practice: 10A NCAC 27G .0209 MEDICATION Process for communication of any patient **REQUIREMENTS** infection or medical concerns is now being (c) Medication administration: completed in the EHR. Once this form is (1) Prescription or non-prescription drugs shall initiated by the nurse, the form with patient only be administered to a client on the written concerns is routed to the provider for order of a person authorized by law to prescribe review. (2) Medications shall be self-administered by Education has been completed with the clients only when authorized in writing by the nursing staff regarding appropriate entry of client's physician. orders. (3) Medications, including injections, shall be administered only by licensed persons, or by Education has been completed with the unlicensed personstrained by a registered nurse, physicians/ providers regarding appropriate pharmacist or other legally qualified person and entry of orders. privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of A standardized process and forms for all drugs administered to each client must be kept completion by the PRTF provider and current. Medications administered shall be consulting physician/ provider is being recorded immediately after administration. The developed to improve communication of MAR is to include the following: consulting care provided to include (A) client's name; instructions for patient care follow up on (B) name, strength, and quantity of the drug; return to PRTF. (C) instructions for administering the drug: (D) date and time the drug is administered; and Education on the standardized Consultation (E) name or initials of person administering the process will be completed with nursing and drug. physician/ provider staff. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR Doctors and all providers have been given 10/26/21 file followed up by appointment or consultation access to the EHR remotely and can enter with a physician. orders immediately. RNs and Therapists will be trained on 11/17/21 ensuring physicians are ordering all discharges and transfers to other levels of care. This Rule is not met as evidenced by: (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B WING 20140058 10/26/2021

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STATE. ZIP CODE 3200 WATERFIELD DRIVE STRATEGIC BEHAVIORAL CENTER-GARNER GARNER, NC 27529 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PRFFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 118 Continued V 118 V 118 Continued From page 34 Measures that will be put in place to Based on record review and interview the facility prevent the problem from occurring failed to ensure medications were administered on the written order of a physician for one of one again: current client (#1) and one of one former client (FC#10) audited for medications. In addition, one HIM will audit all physicians and provider of two nurses (#1) failed to demonstrate orders. HIM will communicate with CMO/ competency. The findings are: Medical Director when providers are not completing audited documentation and A. The following are examples of physician orders report findings in QAPI. not being followed: Infection/ medical concerns documentation Review on 10/18/21 of FC#10's record revealed: and reporting will be reviewed weekly by Admitted 4/21/21 and discharged 9/29/21 the Infection Control Nurse. IC RN will 14 years old report to the CNO any report of concerns Diagnoses of Disruptive Mood for follow up on by the physician/provider Dysregulation Disorder, Major Depressive within 24 hours. Disorder, Trauma & Post Traumatic Stress Disorder Physician/ provider not addressing infection/ medical concerns timely will Review on 10/18/21 of the facility's receive follow up with the CMO or Medical consultation/follow up examination form dated Director. 7/17/21 for FC#10 revealed: "Reason for Consultation: possible Monitoring of Consultation Documentation Herpes and UTI (Urinary Tract Infection)" upon return of Consultation Appointments "History of Present illness: recurred for completeness of patient follow up care. ongoing rash in the pelvic area. Rash itchy. Has sexual history consisted with unprotected Nursing and physician/provider trainings intercourse. Patient exhibiting Dysuria and will be completed 100% of all staff working. increase urinary frequency and back pain" Staff not completing trainings will not be "Assessment/diagnosis: Herpes, UTI and placed on the schedule. Dysuria" "Plan/Orders: Valacyclovir 500 milligrams Who will monitor the situation to ensure (mg) by mouth (PO) daily (herpes virus), Pyridium it will not occur again: 200mg three times daily for 2 days" (UTI) CEO Signed by Physician Assistant (PA) CNO Infection Control Review on 10/20/21 of the Daily Nursing Notes CMO for FC#10 revealed: Medical Director "7/16/21: complained of abdominal pain ...Tylenol given" (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ C B. WING 20140058

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	sensation during urin Medical consult place guardian no answer"  - "7/18/21: co urination and rash1 message for (Departr DSS guardian and he be signed"  - "7/19/21: co chain reaction) testin  - "7/21/21: tra physician's office for prior to departure for Review on 10/21/21 of from the primary phy of Health Service Reg  - "Visit date: 7  - "Chief comp transmitted disease) vaginal bumps, interriritation for past two ending in the primary phy of Health Service Reg  - "Visit date: 7  - "Plan: will of the primary phy of Health Service Reg  - "Visit date: 8  - "Assessment of the vaginal"  - "Follow up and Review on 10/20/21 corder sheet dated 8/6  - Cultarelle Po	mplained of burning ationurine frequency ed to follow upcall to mplain Dysuria, freque fluids encouragedlef ment of Social Services er supervisor for consernsent for PCR (polymeg signed by DSS guard nsported to primary PCR testingTylenol gheadache"  of a faxed medical sum sician's office to the Diversical sician's office to the Diversical sician's office to the Diversical sician's Tylenol gheadache"  of a faxed medical sum sician's office to the Diversical sicia	nt t t s) nt to erase ian" given mary vision aled: t inal SV of red ben 500mg ns of		How often the monitoring will take Daily/ Weekly/ Monthly Monitoring a indicated.  V 118 Ends		JRVEY
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STRATEGIC	BEHAVIORAL CENTE	K-GARNER	GARNER,	NC 27529			
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V 118	Continued From page	e 36		V 118			
	- Metronidazo days	le 500mg twice a day fo	or 7				
	FC#10 revealed:	f the August 2021 MAR					
	Transaction Activity De 7/31/21 for antibiotics	ne facility's pharmacy's etail Report" from 7/17/2 s for FC#10 revealed: es were administered be	1 -				
	Officer) verified	the CNO (Chief Nursin es were administered /21	g				
	agency - 2 staff took h - She was neg - She was onl the facility with Tylen Probiotic for yeast	FC#10 reported: for STDs by an outside ther to the appointment gative for STDs by treated during her sta ol or an over the counte furring UTIs during her sta	er				
	-	ally asked for medicatio	on for				
	Valacyclovir & Pyridit & not on the facility's - Medication o	ne PA listed medications: um on the consultation f physician's order form orders had to be listed on in order for the nurses	om the				
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMB		` '	CONSTRUCTION	(X3) DATE SI COMPLE	
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STRATEG	IC BEHAVIORAL CENTE	R-GARNER	GARNER,	NC 27529			
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V 118	Continued From pag	e 37		V 118			
	- Thought it we that he listed the med and not the physician - There was not antibiotic was given used Medications could not be filled untreviewed the medicated - The facility's an order to be filled be - She was not practitioner did not we 8/6/21 - FC#10 probin - The nurses of the physicians were reproviders wrote physicians were reproviders wrote physicians the facility wend since the facility wend consultation form and physician order form - Either the numbry sician order form - Either the numbry sician was not formation w	ras an oversight by the Fications on the consult of sorder form of documentation an until 8/7/21 is listed from outside provide the facility's physicians tions is physicians would then by the physicians pharmat sure why the facility's Norite the physicians order ably felt some discomforwer responsible for entitied if an outside ician orders tion system had improve the lectronic as of 8/18/21 the PA reported:  1. **HID**  1. **HID**  1. **Incompany the factor of the entities of the pharmater factor of the pharmater failure if FC#10 did prescribed 7/17/21 cian's order for injections.  1. **Client #1's record reveal at the 5/17/21 cian's order for injections.  2. **Client #1's record reveal at the 5/17/21 cian's order for injections.	form  viders  ns  write acy Nurse r until ort and suring  ed 1  on the cility's  t put r the acy not				
	- 16 years old						
	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER		, ,	CONSTRUCTION	(X3) DATE S COMPLE	ETED
		20140058		B. WING		10/2	6/2021

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NAME OF PROVIDER OR SUPPLIER		STF	REET ADDR	ESS, CITY, STAT	E, ZIP CODE		
			00 WATE	RFIELD DRIV	E		
SIRAIEG	IC BEHAVIORAL CENTE		ARNER, N	NC 27529			
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V 118	Continued From page	e 38		V 118			
v 110	- Diagnoses: Dysregulation Disord Disorder/Adolescent Unspecified Mood Di Disorder and Opposi  Review of facility vide incident with Client # - 11:44 PM inj arm (by Nurse #1) - 11:45 PM inj arm (by Nurse #1)  Review on 10/19/21 of 2021's MAR revealed - Medication of listed on 9/25/21 - No signature  Interview on 10/12/21 - Received and because "I wouldn't of Interview on 10/18/21 reported: - Did not see af #1's injection for her of Client #1 wo Zyprexa and Benadry - Nothing was 9/25/21 for an injection - Didn't know documented  Interview on 10/21/21 - She was a Received and the course of the cours	Disruptive Mood er, Conduct onset-type severe, sorder, Cannabis Use tional Defiant Disorder eo on 10/7/21 of the 9/25/21 1 revealed: lection was given in the left lection was given in the rigi of Client #1's September for the injection given was re e of medication being giver Client #1 reported: injection on 9/25/21 alm down" & 10/19/21 the CNO an order on 9/25/21 for clie behaviors and have been given a ly injection for behaviors as signed off on the MAR for on why there was nothing  Nurse #1 reported: legistered Nurse (RN)	not n	V 110			
- The incident on 9/25/21 was her 2nd day working on her own in the facility		ay					
	- Worked 7:00	PM - 7:00 AM ne Nurse Practitioner for					
	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE S COMPLI	
		20140058		B. WING		1 <b>0/2</b>	; 6/2021

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NAME OF PROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STAT	E, ZIP CODE			
STRATEG	IC BEHAVIORAL CENTE	R-GARNER	3200 WATE GARNER,	RFIELD DRIV	E		
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V 118	Continued Frompag	e 39		V 118			
V118	authorization for clier - She gave cli Benadryl injection for - Did not sign given to client # 1  Due to the failure to a medication administr determined if client re ordered by the physic  Review on 10/26/21 of Protection dated 10/2 (Chief Executive Offic -"What immediat to ensure the safety of care?  Verification that all pro access to the Electro completed by end offic Completion of CPOE Order Entry) Training electronically will be of today, 10/26/21.  All providers will rece documentation of ord telephone orders by of 10/26/21.  Nursing staff will rece documentation and w by end of the day tod	at #1's injection on 9/25/sent #1 a Zyprexa and rehaviors the MAR for the injection of the MAR for the injection at the matter of the facility's Plan of 16/21 and signed by the cer's revealed: the action will the facility of the consumers in you widers have access from the day today, 10/26/21. (Computerized Physic grand how to enter order completed by end of the device education on correcters, including verification.	e CEO take ur note be ian rs e day ct on of	V118			
	the Restraint/Seclusi electronic health reco obtain an order from -Describe your p happens.	s been added to initiation on documentation in the ordinstructing the RN to the provider.  I ans to make sure the a lith Information Manage	e bove				
		ns and provider orders.				ı	
	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMB			CONSTRUCTION	(X3) DATE S COMPLI	
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NAME OF PROVIDER OR SUPPLIER		TREET ADD	RESS, CITY, STAT	E, ZIP CODE			
			200 WATE	RFIELD DRIV	E		
STRATEG	IC BEHAVIORAL CENTE		SARNER,	NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118	Continued From pag	e 40		V 118			
V 118	will communicate with when providers are no documention and rep. Assurance Performar 2. Direct car completed to 100% of completing trainings schedule. Trainings a maintained in the HR and added to training reported out in QAPI. 3 Physician trainings will not be p.  Clients ranged in age which included Disru Disorder, Major Depr. Disorder, Post Traum Oppositional Defiant Disorder and Cannat 7/17/21, FC#10 inform an itchy rash in the p. pain. The PA prescriber Valacyclovir on 7/17/ outside provider on 8 Bacterial Vaginitis. Stantibiotic during the 8 receive any medication and until 8/7/21. FC# was only given a Tyle facility's consultation physician's order for orders listed on the p. PA said the medication on both forms and a s. FC#10 from getting the seneeded to relieve the facility of the p. PA said the medication on both forms and a s. FC#10 from getting the seneeded to relieve the facility of the p. PA said the medication on both forms and a s. FC#10 from getting the p. PA said the medication on both forms and a s. FC#10 from getting the p. PA said the medication on both forms and a s. FC#10 from getting the p. PA said the receive and the p. PA said the medication on both forms and a s. FC#10 from getting the p. PA said the receive and the p. PA said the medication on both forms and a s. FC#10 from getting the p. PA said the receive and the p. PA said the receive and the p. PA said the medication on both forms and a s. FC#10 from getting the p. PA said the receive and the p. PA said the recei	n CMO/Medical Director of completing audited fort findings in QAPI (Qualice Improvement).  The staff trainings will be fall staff working. Staff nowell be fall staff working. Staff nowell be placed on the and competencies will be (Human Resources) file of tracking form which is a s/providers not completing laced on the schedule."  The sfrom 14-16 with diagnostices placed on the schedule."  The sfrom 14-16 with diagnostices placed on the schedule.  The signal staff working is signal staff or the schedule.  The signal staff working is signal staff or the schedule.  The complete is staff or the schedule.	ses n t nood ad ack n t e ty's	V 118			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
	OF CORRECTION	IDENTIFICATION NUMBER				COMPL	
						] ,	<u>,                                    </u>
		20140058		B. WING		10/2	; :6/2021

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STATE. ZIP CODE 3200 WATERFIELD DRIVE STRATEGIC BEHAVIORAL CENTER-GARNER GARNER, NC 27529 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PRFFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 118 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 314 V 314 27G .1901 Psych Res. Tx. Facility - Scope V 314 Begins 11/17/21 10A NCAC 27G .1901 SCOPE Measures that will be put in place to (a) The rules in this Section apply to psychiatric correct the deficient area of practice: residential treatment facilities (PRTF)s. Education on the discharge process for (b) A PRTF is one that provides care for children PRTF is being completed with all direct care or adolescents who have mental illness or staff. substance abuse/dependency in a non-acute inpatient setting. Education on the discharge process for (c) The PRTF shall provide a structured living PRTF is being completed with all 11/17/21 environment for children or adolescents who do physicians/ providers. not meet criteria for acute inpatient care, but do require supervision and specialized interventions RNs and therapists have been trained on on a 24-hour basis. ensuring physicians are ordering all (d) Therapeutic interventions shall address discharges and transfers to other levels of functional deficits associated with the child or 11/17/21 care. adolescent's diagnosis and include psychiatric treatment and specialized substance abuse and Restraint/ seclusion policies and processes mental health therapeutic care. These are being reviewed with staff and therapeutic interventions and services shall be physicians/ providers. designed to address the treatment needs necessary to facilitate a move to a less intensive CPI training is being completed with all community setting. direct care staff every six months. (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ C B WING 20140058 10/26/2021

PRINTED: 11/02/2021 FORM APPROVED Division of Health Service Regulation NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STATE. ZIP CODE 3200 WATERFIELD DRIVE STRATEGIC BEHAVIORAL CENTER-GARNER GARNER, NC 27529 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PRFFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 314 Continues V 314 V 314 Continued From page 42 (e) The PRTF shall serve children or adolescents Education of therapy documentation 11/17/21 for whom removal from home or a requirements is being completed with all community-based residential setting is essential clinical therapists. to facilitate treatment. (f) The PRTF shall coordinate with other Additional CPI training and use of deindividuals and agencies within the child or escalation techniques has been assigned to adolescent's catchment area. all direct care staff. (g) The PRTF shall be accredited through one of the following: Joint Commission on Accreditation One Hour Face to Face education has been of Healthcare Organizations; the Commission on reviewed and will be completed with RNs Accreditation of Rehabilitation Facilities; the covering processes and documentation Council on, Accreditation or other national requirements. accrediting bodies as set forth in the Division of Medical Assistance Clinical Policy Number 8D-1, Electronic documentation has been updated Psychiatric Residential Treatment Facility, with a Red Alert notification for the nurse including subsequent amendments and editions. ensuring a provider's order has been A copy of Clinical Policy Number 8D-1 is available completed. at no cost from the Division of Medical Assistance website at http://www.dhhs.state.nc.us/dma/. 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 This Rule is not met as evidenced by: with piercings in currently will be assessed Based on record review and interview, the facility by physicians for safety. failed to ensure a structured living environment with specialized interventions on a 24-hour basis All direct care staff has been trained on all affecting one of ten audited current clients (#1) aspects of verbal de-escalation, milieu and failed to ensure therapeutic interventions management, leadership, roles, responding addressed functional deficits associated with the and responsibilities in codes. child or adolescent's diagnoses affecting six of ten audited current clients (#1, #4, #6, #7, #8 and All direct care staff have been trained on all

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING:

C

20140058

(X3) DATE SURVEY
COMPLETED

C

10/26/2021

aspects of seclusion and restraint to include

observations during and after interventions.

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findings are:

#9). In addition, the facility failed to coordinate

affecting one of ten audited current clients (#4) and one of two former clients (FC#10). The

services with other individuals and agencies

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STATE. ZIP CODE

## 3200 WATERFIELD DRIVE STRATEGIC BEHAVIORAL CENTER-GARNER

GARNER, NC 27529

TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)	DATE
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(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)

## 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 Continued V 314

# 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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Division of Health Service Regulation (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ C. B. WING 20140058 10/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WATERFIELD DRIVE STRATEGIC BEHAVIORAL CENTER-GARNER GARNER, NC 27529 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETE DATE **PREFIX** PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) V 314 Continued V 314 V 314 Continued From page 44 #1, Nurse #2 and House Supervisor) working 100% of One Hour Face to Face during an incident demonstrated competency in documentation will be monitored for completion for 60 days or until 98% Seclusion, Physical Restraint and Isolation Time-Out and one of five staff (#1) training in compliance is achieved for 4 consecutive Seclusion, Physical Restraint and Isolation weeks. Compliance will be reported monthly Time-Out had expired. through QAPI, Med Exec, and Governing Board. E. Examples no individual therapy services provided: Staff not completing the required documentation will receive documentation Review on 10/8/21 of client #1's record revealed: of follow up coaching by the appropriate Admitted 5/17/21 director. Age: 16 Diagnoses: Disruptive Mood Dysregulation Disorder (DMDD), Conduct Who will be monitoring the situation to Disorder/adolescent onset-type severe, ensure it will not occur again: Unspecified Mood Disorder, Oppositional Defiant CEO Disorder (ODD) and Cannabis Use Disorder CNO Treatment Plan dated 9/7/21 listed CMO individual therapy once per week Medical Director Individual therapy completed on 9/9/21 & 9/14/21. No other individual therapy sessions How often the monitoring will take place noted Weekly/ Monthly Review on 10/7/21 of client #4's record revealed: Admitted: 9/1/21 V 314 Ends 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

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PRINTED: 11/02/2021 FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ С B. WING\_ 20140058 10/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WATERFIELD DRIVE STRATEGIC BEHAVIORAL CENTER-GARNER GARNER, NC 27529 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETE DATE **PREFIX** PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) V 314 Continued From page 45 V 314 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 Aae: 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.

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Interview on 10/12/21 the Acting Director of

until 8/23/21, when a new therapist started

Had been promoted in June or July 2021 Was the only person in her department

Clinical Services reported:

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_ C. B. WING 20140058 10/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WATERFIELD DRIVE STRATEGIC BEHAVIORAL CENTER-GARNER GARNER, NC 27529 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETE DATE **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 314 Continued From page 46 V 314 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

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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 understand it [client #41 is not currently covered."]

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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PRINTED: 11/02/2021 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ C. B. WING 20140058 10/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WATERFIELD DRIVE STRATEGIC BEHAVIORAL CENTER-GARNER GARNER, NC 27529 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETE DATE **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 314 Continued From page 48 V 314 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 IPRTF 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 Aresponded: "So does this mean we can move forward with the original plan for tomorrow?"

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tomorrow work."

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

Review on 10/20/21 of email exchanges dated 8/30/21 between client #4's parent and client #4's

"I just wanted to reach out. I heard what

therapist at Sister Facility Arevealed:

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think about it and fix it."

(involuntary committed). She (CEO) said let me

to re-admit client #4 for one night. Sister Facility A and this location would have a meeting point to

The CEO arranged with Sister Facility A

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Sister Facility A.

They were looking to admit her from

They didn't plan to admit her until the

next day. They were going to "meet the Sister

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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 Areported:

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Review on 10/18/21 of an email sent to the

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care?

revealed:

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

1. Verification that all providers have

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reported out in 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

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STRATEGIC BEHAVIORAL CENTER-GARNER  GARNER, NC 27529						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FI REGULATORY OR LSC IDENTIFYING INFORMATI	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
V 314	Continued From page 55  3. Physician's order will be required patients to maintain current piercing's.  4. Physicians/providers not complet trainings will not be placed on the schedule.  This deficiency constitutes a re-cited deficie and must be corrected.	eting ."	V 314			
	Clients ranged in ages from 12-17 with diagrof Post Traumatic Disorder (PTSD), Major Depression, Disruptive Mood Dysregulation Attention Deficit with Hyperactive Disorder (ADHD), Schizophrenia and Oppositional Disorder (ODD) had multiple occasions who they had not received either group or individual therapy once a week as noted in their treatmer plans. Client #4's transfer/admission between Sister Facility A and Strategic Behavioral Center-Garner was not coordinated effective amongst her system of care which included therapist, facility staff, MCO representatives Guardians. This lack of coordination resulted client #4's guardian spending more than 9 her transporting her between the two facilities a returning back to their home. Client #4 was	n, pefiant ere dual ment en ely l s and ed in ours				
	denied admission to Strategic Behavioral Center-Garner on 8/31/21. The CEO said cli #4 was not scheduled for admission on that FC#11's delivery of services for admissions communicated between a care coordinator therapist. The CEO failed to exhibit compete by transferring FC#11 without discharge fro PRTF to the acute unit for safety purposes. transfer was completed without guardian coand a physician's order. FC#10 reported be assaulted in September. The LME/MCO representative reached out to the facility's therapist about the assault with no response the end of this survey. The CEO allowed fer	t date. s were and a ency mthe This onsent ing				

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clients from the 300 hall to retrieve items from the

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		00440050	B. WING		C
		20140058	<i>b.</i> <b>********</b>		10/26/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADDR	RESS, CITY, STAT	E, ZIP CODE	
			RFIELD DRIV	E	
STRATEG	IC BEHAVIORAL CENTE	ER-GARNER GARNER,	NC 27529		
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	()
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	IATE DATE
				DEFICIENCY)	
V 314	Continued Frompag	e 56	V 314		
• • • • • • • • • • • • • • • • • • • •					
	contraband closet su	ch as fake eyelashes and a			
	nose piercing withou	t consulting with a physician			
	to determine safety a	nd hygiene risk. One client			
	_	ye irritation as the clients			
	- · · · · · · · · · · · · · · · · · · ·	hair gel as an adhesive on			
		instructed staff to contact			
		dent on 9/25/21 where client			
	#1 was placed in har				
	-	ompliant with staff orders.			
		g on 9/25/21 did not exhibit			
		falternatives to restrictive			
		clusion and restraint while			
		a behavior where she was			
	_	and run into the nurse's			
		ther client. The staff did not			
		o was being targeted by			
		mediate area. Multiple staff			
		ysical restraint as client #1			
	-	e's station countertop. Client			
	•	, broke the window near the			
		icked opened the door			
		station and the 400 hall			
	_	intervention. Client #1 was			
	T	d in the isolation room . She			
		by the Police for an estimated			
	20 minutes without a	ny facility staff present.			
		nentation that client #1 was			
	monitored during and	d after the restraint in the			
	isolation room. The fa	acility failed to follow their			
	policy for Seclusion a	and Restraint for the incident			
	on 9/25/21. The failu	re of the above mentioned			
	areas constitutes a Ty	pe A1 rule violation for			
	serious neglect and r	must be corrected within 23			
	_	ive penalty in the amount of			
		d. If the violation is not			
	corrected within 23 d				
		ty of \$500.00 per day will be			
	imposed for each day	•			
	compliance beyond t				
		2014 day.			

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Diagnoses: Disruptive Mood

11/17/21

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#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

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FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ С B. WING 20140058 10/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WATERFIELD DRIVE STRATEGIC BEHAVIORAL CENTER-GARNER GARNER, NC 27529 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETE DATE **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 315 Continued From page 59 V 315 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

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hall

staff on the hall but there was never 3 staff on the

If she was "lucky", she would have 1

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FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ С B. WING 20140058 10/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WATERFIELD DRIVE STRATEGIC BEHAVIORAL CENTER-GARNER GARNER, NC 27529 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE DATE **PREFIX** PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) V 315 Continued From page 60 V 315 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 he 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

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7 clients

Should have had 4 MHTs on the hall with

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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

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		20140058	B. WING		C <b>10/26/2021</b>
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STAT	TE, ZIP CODE	10/20/2021
STRATEG	IC BEHAVIORAL CENTE	R-GARNER	ERFIELD DRIV NC 27529	E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
V 315	- 10/15/21-500 staff: 2, nurse: 1 - 10/15/21-300 staff: 2, nurse: 0 - 10/15/21-300 staff: 2, (including Lea - 10/15/21-400 staff: 0, nurse: 1 - 10/16/21-600 staff: 1, nurse: 1 - 10/17/21-300 staff: 2, nurse: 1 - 10/17/21-500 staff: 1, nurse: 1 - 10/17/21-500 staff: 1, nurse: 1 - 10/17/21-600 staff: 1, nurse: 1 - 10/18/21-300 staff: 1, nurse: 1 - 10/18/21-300 staff: 1, nurse: 1 - 10/18/21-500 staff: 1, nurse: 1 - 10/18/21-500 staff: 1, nurse: 2 Interview on 10/25/21 reported: - Staffing ratio Psychiatric Residenti - PRTF would was a call out - Not sure how	hall night staff census: 5, hall night shift census: 6, hall day shift census: 6,	V 315	DEFICIENCY)	
	staff on the hall but th hall	at there should be at least 3 ere was never 3 staff on the ucky", she would have 1			

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FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ С B. WING 20140058 10/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WATERFIELD DRIVE STRATEGIC BEHAVIORAL CENTER-GARNER GARNER, NC 27529 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETE DATE **PREFIX** PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) V 315 Continued From page 63 V 315 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 "alwavs." 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

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The census has dropped since the

"State" has been in doing their surveys Worked six days a week

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PRINTED: 11/02/2021 FORM APPROVED Division of Health Service Regulation (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ С B. WING 20140058 10/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WATERFIELD DRIVE STRATEGIC BEHAVIORAL CENTER-GARNER GARNER, NC 27529 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 315 Continued From page 64 V 315 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

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their needs

- The CEO was "pushing" to increase admissions while not having enough staff to meet

There were not enough MHTs, nurses

and therapists to increase the census

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FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ С B. WING 20140058 10/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WATERFIELD DRIVE STRATEGIC BEHAVIORAL CENTER-GARNER GARNER, NC 27529 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETE DATE **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 315 Continued From page 65 V 315 "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

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was only one staff working on the hall

would be working alone on the hall

- On 9/25/21 was not sure why staff #1

- Staff #2 was a new employee shadowing

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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

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the clients were in class out of ratio.

and the staffing was always out of ratio.

Went on the floor several times a week

MHTs complained to her about not having

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clients for one staff to be on the hall.

see who was supposed to work with him.

- He explained staff schedule was not

She told him to view the staff schedule to

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ C. B. WING 20140058 10/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WATERFIELD DRIVE STRATEGIC BEHAVIORAL CENTER-GARNER GARNER, NC 27529 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETE DATE **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 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

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the physical altercation, they all denied an

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1. Patient census and staffing will be discussed daily to ensure adequate staffing

to include this "float" position. The scheduling coordinator will be instructed to immediately notify the CNO in advance for challenges related to

2. Staffing assignment sheets will be modified

including the "float" position.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WING		С
		20140058	B. WING		10/26/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STAT	E, ZIP CODE	
STRATEC	IC BEHAVIORAL CENTE		TERFIELD DRIV	E	
SIRAIEG	IC BEHAVIORAL CENTE	GARNER	, NC 27529		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(* /
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V 315	Continued From page	e71	V 315		
	staffing.				
	•	ccur with all direct staff to			
		with the role of the 'float'			
	staff.				
		isors will be trained to			
	contact AOC with any	staffing concerns			
	immediately"				
	Cliente renged in age	es from 12-17 with diagnoses			
	0 0	ptive Mood Dysregulation			
	Disorder, Conduct Di				
		nspecified Mood Disorder,			
	• •	s Disorder, Cannabis Use			
	Disorder and Opposi	tional Defiant Disorder.			
		were out of compliance in			
		educational setting on			
	several occasions. C				
		ed between 5-12 clients. Over			
		eview of 18 total shifts, the oted 17 occurrences of non			
		ing ratios. The educational			
	•	taffing ratios to provide			
	•	re learning environment for			
		s. The facility staff were not			
		and it was unclear whether			
		dered in the staff/client ratio.			
		g, one staff was injured as			
		n an incident between two			
	•	ern on that day was 1 staff to			
		tation of the assignment ate with staff present and on			
	duty at the time. The				
	mentioned areas cons				
	violation for serious r				
		ays. An administrative			
	penalty in the amoun	of\$3,000.00 is imposed. If			
		rrected within 23 days, an			
		tive penalty of \$500.00 per			
		or each day the facility is out			
	of compliance beyon	d the 23rd day.			

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_ C. B. WING 20140058 10/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WATERFIELD DRIVE STRATEGIC BEHAVIORAL CENTER-GARNER GARNER, NC 27529 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FIIII (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) V 536 Begins V 536 V 536 27E .0107 Client Rights - Training on Alt to Rest. Int. Measures that will be put in place to correct the deficient area of practice: 10A NCAC 27E .0107 TRAINING ON Re-education of restraint/ seclusion processes is 11/12/21 ALTERNATIVES TO RESTRICTIVE being completed with all direct care staff. **INTERVENTIONS** (a) Facilities shall implement policies and All direct care staff are being trained on all practices that emphasize the use of alternatives aspects of verbal de-escalation, milieu to restrictive interventions. management, leadership, roles, responding and (b) Prior to providing services to people with responsibilities in codes. disabilities, staff including service providers, All direct care staff will be trained on all aspects employees, students or volunteers, shall of seclusion and restraint to include observations demonstrate competence by successfully during and after interventions. completing training in communication skills and other strategies for creating an environment in CPI training is being completed with all direct which the likelihood of imminent danger of abuse care staff at least every 6 months. or injury to a person with disabilities or others or property damage is prevented. One Hour Face to Face education has been (c) Provider agencies shall establish training reviewed with RNs covering processes and documentation requirements. based on state competencies, monitor for internal compliance and demonstrate they acted on data Physician/provider education has been provided gathered. on restraint/ seclusion documentation (d) The training shall be competency-based, requirements including guidelines for restraint/ include measurable learning objectives, seclusion orders. measurable testing (written and by observation of behavior) on those objectives and measurable 100% of all restraint/ seclusion documentation methods to determine passing or failing the will be reviewed for the next 60 days or until 98% course. compliance has been achieve for 4 consecutive (e) Formal refresher training must be completed weeks. Monthly audits of restraint/ seclusion by each service provider periodically (minimum documentation will continue and outcomes will be reported in QAPI, Med Exec and Governing annually). Board Meetings. (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; recognizing and interpreting human

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(2)

Trainers shall demonstrate competence

Trainers shall demonstrate competence

by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the

by scoring a passing grade on testing in an

need for restrictive interventions.

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С B. WING 20140058 10/26/2021

NAME OF PROVIDER OR SUPPLIER  STRATEGIC BEHAVIORAL CENTER-GARNER	STREET ADDRESS, CITY, STATE, 3200 WATERFIELD DRIVE	ZIP CODE	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FU TAG REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
instructor training program.  (3) The training shall be competency-based, include measurable lear objectives, measurable testing (written and to observation of behavior) on those objectives measurable methods to determine passing of failing the course.  (4) The content of the instructor training service provider plans to employ shall be approved by the Division of MH/DD/SAS pure to Subparagraph (i)(5) of this Rule.  (5) Acceptable instructor training progshall include but are not limited to presentating.  (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 expensionable at training program aimed at prevent reducing and eliminating the need for restriction interventions at least one time, with positive review by the coach.  (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating need for restrictive interventions at least one 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 at least three years.  (1) Documentation shall include:  (A) who participated in the training and outcomes (pass/fail);  (B) when and where attended; and instructor's name.  (C) instructor's name.	or sand sand or sand sand sand sand sand sand sand sand		

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FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ С B. WING 20140058 10/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WATERFIELD DRIVE STRATEGIC BEHAVIORAL CENTER-GARNER GARNER, NC 27529 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETE DATE **PREFIX** PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) V 536 Continued From page 75 V 536 request and review this documentation any time. (k) Qualifications of Coaches: Coaches shall meet all preparation (1) requirements as a trainer. Coaches shall teach at least three times the course which is being coached. Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (I) 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:

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Hire date of 9/24/21

CPI training completed 9/21/21

Review on 10/11/21 of House Supervisor's record

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FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ C. B. WING 20140058 10/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WATERFIELD DRIVE STRATEGIC BEHAVIORAL CENTER-GARNER GARNER, NC 27529 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 536 Continued From page 76 V 536 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 hand cuffs 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

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talking to patient to calm down."

Report completed by House Supervisor

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
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		20140058	B. WING		C <b>10/26/2021</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STAT	TE, ZIP CODE	
			ERFIELD DRIV	'E	
STRATEG	SIC BEHAVIORAL CENTE		NC 27529		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON (X5)
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V 536	Continued From pag	e 77	V 536		
	Review on 10/11/21 o	of a Police report regarding			
	client#1 dated 9/25/2				
	"Reporting Party				
		the incident began over two			
		to go back to their original			
		insferred from. [Staff #1]			
	<u> </u>	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			
		amaged & the door window			
		ne. After that initial incident			
		atients on the hallway			
	became angry and be	-			
	throughout the hallwa	ay.			
	Officer Involvem	ent:			
	_	[client#1] became violent			
		gadoor in order to get out			
		t#1] was then placed in			
	handcuffs & escorted	I to an isolated room. The			
	nurse then advised th	nat they would administer			
	=	almher down. After the shot			
		1], the handcuffs were			
	-	then attempted to leave the			
		th time the nursing staff			
		she was not to leave the			
		ame violent&had to be eroomby myself&[Police			
	Officer #2].	eroomby mysen a fronce			
	•	eroom[client#1] began			
		ficer #2]. [Police Officer#2]			
		echnique to maintain a safe			
		n & [client#1]. [Client#1]			
		sault[Police Officer] again			
	•	int technique was applied by			
		stop the assault by [client			
		fthen took control of [client			
	_	law enforcement assistance			
		ed. The watch commander,			
	[Lieutenant] was notif	fied of this incident by [Police			

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9/25/21 was her second day of training

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_ C. B. WING 20140058 10/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WATERFIELD DRIVE STRATEGIC BEHAVIORAL CENTER-GARNER GARNER, NC 27529 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETE DATE **PREFIX** PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 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

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and they were not listening to the staff.

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A male staff (House Supervisor) came in

- 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.

and told him to place her in a room that had

padded walls (isolation room).

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to assist

room

spear technique"

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

Police Officer #2 had to use "force-the

During this time the staff started to come

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Staff then brought in a shot and she was

One staff (Nurse #2) said she was a new

contractor 1st or 2nd night working and said, "I

ok with the shot and asking for it.

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Told client #1 to back up, she tried to get

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FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ С B. WING 20140058 10/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WATERFIELD DRIVE STRATEGIC BEHAVIORAL CENTER-GARNER GARNER, NC 27529 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) V 536 Continued From page 84 V 536 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\*\*I 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

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(CMO) stated:

Interview on 10/21/21 the Chief Medical Officer

9/25/21 yesterday (10/20/21) from a colleague

Was just made aware of the incident on

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ С B. WING 20140058 10/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WATERFIELD DRIVE STRATEGIC BEHAVIORAL CENTER-GARNER GARNER, NC 27529 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETE DATE **PREFIX** PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) V 536 Continued From page 85 V 536 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 psychiatrichospital. 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:

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occurred on 9/25/21

Was on vacation during the incident that

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ С B. WING 20140058 10/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WATERFIELD DRIVE STRATEGIC BEHAVIORAL CENTER-GARNER GARNER, NC 27529 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETE DATE **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 536 Continued From page 86 V 536 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 dees calated 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.

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PRINTED: 11/02/2021 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ С B. WING 20140058 10/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WATERFIELD DRIVE STRATEGIC BEHAVIORAL CENTER-GARNER GARNER, NC 27529 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETE DATE **PREFIX** PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) V 536 Continued From page 87 V 536 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

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ITO

V 537

days.

NCAC 27G .1901 Scope (V314) for a Type A1 rule violation and must be corrected within 23

27E .0108 Client Rights - Training in Sec Rest &

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V 537

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_ C. B. WING 20140058 10/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WATERFIELD DRIVE STRATEGIC BEHAVIORAL CENTER-GARNER GARNER, NC 27529 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETE DATE **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 537 Begins V 537 Continued From page 88 V 537 Measures that will be put in place to 10A NCAC 27E .0108 TRAINING IN correct the deficient areas of practice: SECLUSION, PHYSICAL RESTRAINT AND Re-education of restraint/ seclusion processes is being completed with all direct care staff. ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation All direct care staff have been trained on all time-out may be employed only by staff who have aspects of verbal de-escalation, milieu been trained and have demonstrated management, leadership, roles, responding and competence in the proper use of and alternatives responsibilities in codes. to these procedures. Facilities shall ensure that staff authorized to employ and terminate these All direct care staff will be trained on all aspects procedures are retrained and have demonstrated of seclusion and restraint to include observations competence at least annually. during and after interventions. (b) Prior to providing direct care to people with CPI training is being completed with all direct disabilities whose treatment/habilitation plan care staff at least every 6 months. includes restrictive interventions, staff including service providers, employees, students or One Hour Face to Face education has been volunteers shall complete training in the use of reviewed with RNs covering processes and seclusion, physical restraint and isolation time-out documentation requirements. and shall not use these interventions until the training is completed and competence is Physician/provider education has been provided demonstrated. on restraint/ seclusion documentation (c) A pre-requisite for taking this training is requirements including guidelines for restraint/ demonstrating competence by completion of seclusion orders. training in preventing, reducing and eliminating the need for restrictive interventions. 100% of all restraint/seclusion documentation will be reviewed for the next 60 days or until 98% (d) The training shall be competency-based, compliance has been achieve for 4 consecutive include measurable learning objectives, weeks. Monthly audits of restraint/ seclusion measurable testing (written and by observation of documentation will continue and outcomes will behavior) on those objectives and measurable be reported in QAPI, Med Exec and Governing methods to determine passing or failing the Board Meetings. 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 shallindude,

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PRINTED: 11/02/2021 FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_ C. B. WING 20140058 10/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WATERFIELD DRIVE STRATEGIC BEHAVIORAL CENTER-GARNER GARNER, NC 27529 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETE DATE **PREFIX** PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) V 537 Continued From page 89 V 537 Measures that will be put in place to but are not limited to, presentation of: prevent the problem from occurring refresher information on alternatives to 100% of all restraint/seclusion documentation the use of restrictive interventions: will be reviewed for the next 60 days or until 98% guidelines on when to intervene (2) compliance has been achieve for 4 consecutive (understanding imminent danger to self and weeks. Monthly audits of restraint/ seclusion others): documentation will continue and outcomes will (3) emphasis on safety and respect for the be reported in QAPI, Med Exec and Governing rights and dignity of all persons involved (using Board Meetings. concepts of least restrictive interventions and incremental steps in an intervention); Nursing staff not completing the required strategies for the safe implementation documentation will receive follow up by the CNO of restrictive interventions; or designee. Documentation of the follow up provided will be maintained in the personnel file. (5) the use of emergency safety interventions which include continuous Physicians/providers who are found not assessment and monitoring of the physical and completing required documentation or psychological well-being of the client and the safe appropriate orders will receive follow up by the use of restraint throughout the duration of the CMO, Medical Director or supervising physician. restrictive intervention; (6) prohibited procedures; PI Indicators have been established and (7)debriefing strategies, including their reporting of audits will be reported in QAPI importance and purpose; and Meetings, Med Exec and Governing Board documentation methods/procedures. Meetinas. (h) Service providers shall maintain Direct care staff trainings will be completed to documentation of initial and refresher training for 100% of all staff working. Staff not completing at least three years. trainings will not be placed on the schedule. Documentation shall include: (1) Trainings will be maintained in the HR file and (A) who participated in the training and the added to training tracking form which is reported outcomes (pass/fail); out in QAPI. (B) when and where they attended; and (C) instructor's name. Who will monitor the situation to ensure The Division of MH/DD/SAS may (2)it will not occur again: review/request this documentation at any time. CEO (i) Instructor Qualification and Training CNO Requirements: House Supervisors Trainers shall demonstrate competence СМО by scoring 100% on testing in a training program

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aimed at preventing, reducing and eliminating the

Trainers shall demonstrate competence

need for restrictive interventions.

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Medical Director

Daily/ Weekly/ Monthly

How often the monitoring will take place:

11/17/21

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				V 537 Ends		
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLE	;
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Division	of Health Service Regu	ılation				
V 537	Continued From pag	e 90	V 537			
	by scoring 100% on t	esting in a training program				
		eclusion, physical restraint				
	and isolation time-ou					
	' '	nall demonstrate competence				
		grade on testing in an				
	instructor training pro					
	(4) The training					
		include measurable learning ble testing (written and by				
	-	rior) on those objectives and				
		s to determine passing or				
	failing the course.					
		nt of the instructor training the				
	service provider plan	is to employ shall be				
		sion of MH/DD/SAS pursuant				
	to Subparagraph (j)(6					
		instructor training programs				
		be limited to, presentation				
	of:	ing the adult learner;				
	` '	r teaching content of the				
	course;	i leaching content of the				
	•	of trainee performance; and				
		tion procedures.				
	' '	nall be retrained at least				
	· ,	strate competence in the use				
	of seclusion, physica	al restraint and isolation				
	time-out, as specified	d in Paragraph (a) of this				
	Rule.					
		nall be currently trained in				
	CPR.					
	• •	fractrictive interventions at				
		frestrictive interventions at a positive review by the				
	coach.	a positive review by the				
		nall teach a program on the				
	` '	rventions at least once				
	annually.					
	(11) Trainers sh	all complete a refresher				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
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	L.,,			l .		

Division of Health Service Regulation

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Division	of Health Service Regu	lation				_
V 537	Continued From page	e 91	V 537			
V 337	instructor training at let (k) Service providers documentation of inititraining for at least that (1) Documentat (A) who particip outcome (pass/fail); (B) when and w (C) instructor's (2) The Division review/request this dot (I) Qualifications of C (1) Coaches shrequirements as a train (2) Coaches shimes, the course whi	east every two years. shall maintain ial and refresher instructor ree years. tion shall include: bated in the training and the where they attended; and sname. In of MH/DD/SAS may becumentation at any time. Coaches: hall meet all preparation iner. hall teach at least three ch is being coached. hall demonstrate eletion of coaching or fuction. shall be the same	V 337			
	failed to ensure five of #1, Nurse #2 and Hord during an incident de Seclusion, Physical F Time-Out and one of Seclusion, Physical F Time-Out had expired Review on 10/11/21 of revealed:  - Hire date of #2	nd record review the facility of five staff (#1, #2, Nurse use Supervisor) working emonstrated competency in Restraint and Isolation five staff (#1) training in Restraint and Isolation d. The findings are:				
	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPL	
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Division	of Health Service Regu	lation				
V 537	Continued From pag	e 92	V 537			
	Review on 10/24/21 or revealed:					
		9/24/21 completed 9/21/21				
	Review on 10/11/21 or revealed:	of House Supervisor's record				
	<ul><li>Hire date of NCI refresher</li></ul>	2/19/18 er training completed 5/20/21				
	Review on 10/24/21 of Hire date of	of staff #1's record revealed: 5/18/17				
	<ul> <li>CPI training</li> </ul>	expired 3/12/21				
	Review on 10/24/21 of	of staff #2's record revealed: 8/3/21				
	- NCI training	completed 9/17/21				
	Review on 10/20/21 of for Client#1 revealed	of the Facility Incident Report I:				
	- Incident dat	e: 9/25/21 unable to control the situation,				
		oron Call) [Chief Executive				
		alled to permit police back				
	•	d to back up staff because to control residents' unsafe				
		ice presences, patient [client				
		olice handcuffs because she				
		ng the unit door to go out of police "I will kick until police				
		police rwill kick diffil police				
		t stop, she was placed in				
		to the quiet room. After				
	-	nt, she refused to stay in the asked to stay. When police				
		from going out, she started				
	kicking and punching	the police. Resident wrestle				
		were able to hold her. During				
CTATEMENT	of Deficiencies	sk police to allow him to  (X1) PROVIDER/SUPPLIER/CLIA	(Y2) MI II TIDI E	CONSTRUCTION	(X3) DATE S	LIDVEV
	OF CORRECTION	IDENTIFICATION NUMBER:	, ,		COMPL	
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Division	of Health Service Regu	llation				
V 537	Continued From pag	e 93	V 537			
	continue talking to pa - Report com	atient to calm down." pleted by House Supervisor				
	dated 9/25/21 reveals - No document or physical aggressic - No document - No document in the isolation room	ntation of unsafe behaviors				
	client throughout her	time in the isolation room or o her hall throughout the				
	Seclusion and Restra	of the facility policy on aint policy revealed: ation for Emergency Safety				
	All restraint	techniques or seclusion will registered nurse in the				
	patient's medical reco					
	and shall address the	e behavior at time of release) e failure of less restraint or				
	the end of the shift or	tation must be completed by n which the intervention				
	occurs. The Restrai	nt or seclusion/Flow sheet				
	must have an observ	ration entry by the assigned in initiation of				
	the restraint or seclus	sion and observation of the				
		nuous. The RN [Registered				
		s completed at initiation and ereafter and includes, as				
	•	e of restraint or seclusion				
	<ul> <li>A. signs of applying restraint/sec</li> </ul>	any injury associated with clusion				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE S COMPL	
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V 537   Restraint or seclusion Guidelines:	Division	<u>of Health Service Regu</u>	lation				
- When a patient is in the seclusion room heishe 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 hand cuffs 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 PM. an Officer is seen looking into the window while he held the isolation room door shut with his foot  - 11:14 PM nurse #1 and Nurse #2 enter the isolation room with medication in hand_appeared she did not take the oral medication  - 11:24 PM Nurse #1 and Nurse #2 enter the isolation room with least of uside the door  - 11:34 PM hand cuffs were removed with police as staff #3 artived, client #1 attempted to attack the Police Officers, then the House Supervisor arrived in the roomthe House Supervisor supervisor supervisor	V 537	Continued From pag	e 94	V 537			
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 sectious or room continuously assessing, monitoring, and evaluating the physical and psychological well-being of the patient in sectusion.*  Below are examples of staff not demonstrating competency in Sectusion, 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 PM, an Officer is seen looking into the window while he held the isolation room door shut with his foot  - 11:14 PM Nurse #1 and Nurse #2 enter the isolation room with medication in hand…appeared she did not lake the oral medication  - 11:44 PM officer is seen looking into the window with his foot of the patient with the seen of the patient of the patient with the foot of the patient with the foot of the patient with his foot of the patient with the foot of the patient with his foot of th		Restraint or	seclusion Guidelines:				
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Division of Health Service Regulation

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Division	of Health Service Regu	lation				_
V 537	Continued From pag	e 95	V 537			
		ead Mental Health in the room with client #1 ent #1 left the isolation room.				
	footage from the 9/25 revealed that from 9: were multiple occasion. Nurse #1, Nurse #2 add not exhibit composeclusion, Physical Fime-out with the escalients on the hall. Min verbal and physical not intervene to preveto a response from the clients behaviors. Clients	Restraint and Isolation calating behaviors of the ultiple clients were engaging al aggression and staff did ent futher behaviors leading are Police to address the ent #1 was placed in the ot monitored at all times				
	reported: - A code purp - They couldr	the House Supervisor le was called on hall 300. n't get control of the hall.				
	- The AOC fo Executive Officer (CE	dministrator On Call (AOC). r 9/25/21 was the Chief EO). EO that all resources had				
	- The CEO stace.	ated she was okay with him				
	alone.	was her second day working				
	another agency. - There were t (MHT) staff on the 30	ontract nurse through wo Mental Health Technician 0 hall that shift s "kind of scared" so she				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,	E CONSTRUCTION	(X3) DATE S COMPL	
		20140058	B. WING		10/2	) 16/2021
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Division	<u>of Health Service Regu</u>	lation				
V 537	Continued From page	e 96	V 537			
	stayed out at the nurs	se's station.				
	- Was training	g the Nurse #2 who was in				
	her 2nd day of orient					
	<ul> <li>She adminis</li> </ul>	stered the chemical restraint				
	on client#1.					
	<ul> <li>As the nurse</li> </ul>	e, she was supposed to				
	check on clients ever	y 15 minutes while in the				
	isolationroom					
		you go in the isolation room				
		f not, you check through the				
	door and ask them if t					
		ember documenting her				
		n 9/25/21 while she was in				
		ut did check on her several				
	times.					
		upposed to stay with the				
		lation room monitoring them				
	through the door.					
	Interview on 10/18/21	the Nurse #2 stated:				
	- Worked as a	a contract nurse				
	- 9/25/21 was	her second day of training				
	and first day on the u	nit.				
	<ul> <li>Was trained</li> </ul>	under Nurse #1.				
		rst through the door to the				
	nurse's station and it	_				
		called because the clients				
	were attacking staff#	1 and she was hit in the				
	head with the clip boa	ard and the window was				
	broken.					
		ke she should have gone on				
	the hall to assist sinc	e it was her second day of				
	training.					
		client #1 her medication after				
	the Police handcuffed					
		s in the isolation room for				
		a long time for her to calm				
	down.					
	nurse documented th	eck on her, but the other				
0747544544			(VO) MUUTIDUE	CONCEDITORIO	()(0) 5 4 7 5 0	115) (5) (
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE S COMPL	
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STRATEG	IC BEHAVIORAL CENTE					
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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Division of Health Service Regulation

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Division	of Health Service Regu	lation				
V 537	Continued From pag	e 97	V 537			
	Interview on 10/18/21	Staff #2 stated:				
	<ul> <li>9/25/21 was the 300 floor.</li> </ul>	s her second night working on				
		ember what she was doing as				
	not on the hall with st					
		adowing staff#1 on that shift was floating between halls.				
		seven clients on the hall that				
	- Client#1 ha another client.	d been trying to attack				
		y client#1 was not				
	restrained.	a co-worker being "beat" in				
		oard by a client on hall 300				
	<ul> <li>Was "intimid clients on the hall.</li> </ul>	dated" by a couple of the				
	chemis on the hall.					
	Interview on 10/21/21 stated:	the Police Officer #1				
	- Responded on 9/25/21.	to an incident at the facility				
	· · · · · · · · · · · · · · · · · · ·	because the clients were				
	instruction	and not following staff				
		I the unit was in "disarray"				
	nurse's station was b	the window leading to the roken out				
		roamed around the hall freely.				
	_	staff" on the hall at that time. be 7 or 8 clients				
	<ul> <li>Some client and they were not list</li> </ul>	s were screaming and yelling				
		end of the hall where the				
	loudest clients were l	ocated alk to them and listen to their				
	side					
STATEMENT	or DEFICIENCIES	them back in their room and  (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIPI F	E CONSTRUCTION	(X3) DATE S	SLIDVEV
	OF CORRECTION	IDENTIFICATION NUMBER:	, , -	CONSTRUCTION	COMPL	
		20140058	B. WING			26/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
STRATEG	IC BEHAVIORAL CENTE	R-GARNER 3200 WATI	RFIELD DRIV NC 27529	/E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
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Division	of Health Service Regu	lation				
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	they refused, so he co	ontinued to just listen to				
	- He and the o	other Officers were waiting on				
		re just standing around				
		d try to get them back in her				
	room and she could r					
	cooperate	3				
	- Once a supe	ervisor was on the scene, the				
	staff wanted the Office their rooms	ers to help get the clients in				
	- The clients of	continued to be loud and not				
	listening					
	<ul> <li>Then at one</li> </ul>	point, client #1 walked				
		ass window at the nurse's				
		elling and screaming then				
		oor to the nurse's station				
		ed the door it was coming				
	open.					
		stop or he would put her in				
	handcuffs.	ial llaustura in austra ll				
		id, "put me in cuffs."				
	around him.	time, no staff was immediately				
		taff in the nursing station.				
		d client #1 in handcuffs due to				
	her continuing to kick					
	_	aff for a place to put client #1				
		(House Supervisor) came in				
		her in a room that had				
	padded walls (isolation					
	- The door to	this room did not lock so				
	another Officer had to	o stand by the door with his				
	foot on the door to ke	ep her from getting out as				
	she was still continui	_				
		s foot was holding her in so				
	she was not able to k					
		aff was moving around the				
		ee staff stand by the door ne staff was just walking				
	,	, ,				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPL	
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		20140058	B. WING		10/2	26/2021
NAME OF F	ROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STAT	TE, ZIP CODE		
STRATEG	SIC BEHAVIORAL CENTE		RFIELD DRIV	Æ		
UNATE	SO DESIGNACIONAL OLNIE	GARNER,	NC 27529			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
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			1,10	DEFICIENCY)		

Division	<u>of Health Service Regu</u>	ılation				
V 537	Continued From pag	e 99	V 537			
	around."					
	- He went bac	ck to the hallway and another				
	Officer (Police Office					
	<ul> <li>He talked to</li> </ul>	the clients to let them blow				
	off steam.					
	<ul> <li>One staff (st</li> </ul>	taff #1) stayed at the end of				
	the hall and talked to					
	<ul> <li>After a while</li> </ul>	e, the staff came up with a				
	plan to sedate client #					
		isolation room client #1				
	remained in handcuf					
		#1 received her medication,				
		d to talk to her informing her				
	-	ne hand cuffs if she remained				
	calm.					
		time, the nurse was in and out				
		, but not sure if she was				
	checking client #1's v					
		ot client #1 to stand and ffs, client #1 assaulted one				
	of the Officers.	ns, chefft# i assaulted offe				
	_	shed forward toward Police				
	Officer #2 who was in					
		er#2 stood in front of				
	another officer to bloo					
	pushed/hit or kicked					
		r back in the isolation room				
		told her to calm down but				
	she tried to punch, ki					
		er#2 pushed her back in the				
	room	·				
	<ul> <li>Police Office</li> </ul>	er#2 had to use "force-the				
	spear technique"					
	<ul> <li>During this t</li> </ul>	time the staff started to come				
	to assist.					
	<ul> <li>The staff wa</li> </ul>	s around the door at the				
	time.					
		nd two male staff were right				
	outside the door.					
	- The force wa	as used to keep her from				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	EIED
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			ERFIELD DRIV	/E		
STRATEG	IC BEHAVIORAL CENTE	ER-GARNER GARNER,	NC 27529			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI		COMPLETE DATE
IAG	TEODERION ON	LOG IDENTIFICIATION (INTERPRETATION)	IAG	DEFICIENCY)	L	2,112
division of III	alth Camina Danielatia		1	1		

Division	<u>of Health Service Regu</u>	lation	1	Ī		
V 537	Continued From pag	e 100	V 537			
	pushing out of the isc	olation room they used				
	the"arm bar techniqu	e."				
	- The staff ca	me into the isolation room				
	and they did not inter	vene.				
		s just saying her name but				
	never saw the staff re					
		entually calmed down and he				
	left the area.					
	Interview on 10/21/21	the Police Officer #2				
	stated:					
		he facility on 9/25/21 later as				
		out heard the call and spoke				
		and could tell the situation				
		sked him to come help them				
	out Arrived at th	e facility around 11:30-11:45				
	PM.	e lacility around 11.50-11.45				
		were verbally "hostile."				
		al a few clients were in the				
		d stuff thrown everywhere.				
	- The clients	were sitting on the ground				
	_	no had "zero control of the				
	situation."					
		n the scene told him they had				
		ling cell" (isolation room)				
	who was irate and ho					
		the hall and talked to client				
	take the handcuffs of	om and she kept asking to				
		ere was a reason she was in				
	them					
	- Staff then "b	roughtin a shot and she was				
	ok with the shot and					
	- One staff (N	urse #2) said she was new				
	contractor 1st or 2nd	night working and said, "I				
	don't even know wha					
		e #2 if she would be coming				
	back and she said "n	o" window was broken near the				
AT4T514514T			(VO) MUUTIDUE	CONCTRUCTION	()(0) 5 475 6	115) (5) (
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPL	
			A. BOILDING.			
		20140058	B. WING		10/2	) 16/2021
NAME OF P	ROVIDER OR SUPPLIER		RESS CITY STAT	TE ZIP CODE	10,2	.0/2021
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  3200 WATERFIELD DRIVE					
STRATEG	IC BEHAVIORAL CENTE					
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI		COMPLETE DATE
		- ,		DEFICIENCY)		

Division	of Health Service Regu	ılation				
V 537	Continued From pag	e 101	V 537			
	office area					
	- Never saw t	he staff trying to control client				
	#1 while he was pres					
	- While he wa	s observing client #1 in the				
	isolation room, only s	saw nurse #2 come in and				
	out, and the officers v	were the ones handling client				
	#1					
		as sitting on the floor				
		other staff members around"				
		se came to give client #1 a				
	second "shot"	1.6				
		left arm and client #1 was				
	"ok"					
		e staff "snatched" at her arm				
	to roll her sleeve up f	or the injection ff not to do that and he				
		Ther sleeve because she is				
	already irate"	THE SIEEVE DECAUSE SHE IS				
		l with client #1 and if she				
		ıld take the handcuffs off				
		indcuffs off and she walked				
	out to the main hall					
		cer was standing in the door				
	and client #1 hit the o					
		en tried to grab her hand and				
	she swung at him	and in and abacquing at him				
	saying, "get the f**k o	oped in and she swung at him				
		to block her hand and "put				
	her in an arm bar"	to block her hand and put				
		nat staff was doing, I was too				
	busy blocking punch					
		1 back in the room with "a				
	wrist lock on her face	<b>.</b> "				
	- Let client#1	go, she then jumped at him				
	and kicked him twice					
	<ul> <li>Told client#</li> </ul>	#1 to back up, she tried to get				
	to the door and she s	swung and hit him in the				
	shoulder					
	- Client#1 trie	ed to swing again, then he				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		20140058	B. WING		10/2	26/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
			RFIELD DRIV	Æ		
STRATEG	GIC BEHAVIORAL CENTE	ER-GARNER GARNER,	NC 27529			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI		COMPLETE DATE
0			.,,,	DEFICIENCY)		
	<u> </u>		1			

Division of Health Service Regulation

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Division	of Health Service Regu	ılation				
V 537	Continued From pag	e 102	V 537			
	sternum against the v - Client #1 wa scratching and tried t	as reaching with other hand				
	- It was two m that came in the isola	s name over and over." nales and one female staff ation and said "they got her." y, where the h**l y'all been"				
		ero control, I have seen more er on 5th grader supervision" 'n mess"				
	- "I showed u they (staff) were drov	p to the clean up because vning"				
		n in the middle of a facility, tc. with no staff trying to do kind of situation"				
	- One staff (st	taff #1) had a good rapport rest were just bumps on a				
	- "In my opini	ion, they (staff) should have a ) a*s, not me to have to				
	her head" and the oth	off (Nurse #2) seemed "over ner staff was "completely us (Police Officers) to do				
	- "There need has been the worst!	Is to be something done, this have seen this facility" and here since they opened years				
	(CMO) stated: - Was just ma 9/25/21 yesterday (10	the Chief Medical Officer de aware of the incident on 0/20/21) from a colleague				
	years - Police shou	chiatric treatment for 21 Id not be in a hospital, they unit and restrain someone,				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE S COMPL	ETED
		20140058	B. WING		10/2	26/2021
	ROVIDER OR SUPPLIER	3200 WATE	RESS, CITY, STA ERFIELD DRIV NC 27529	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
				•		-

Division of Health Service Regulation

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Division	<u>of Health Service Regu</u>	ılation					
V 537	Continued From pag	e 103	V 537				
	"it illegal."						
	- Staff should	I have handled the situation					
	and contacted the do						
		oes not work, you do not use					
	the police, "that does	ose decision it was to call the					
	police, but that shoul						
		d constant training to handle					
	the clients	a constant anning to manale					
	- "How can yo	ou run a hospital with new					
	people and no trainir	ng?"					
	Interview on 10/18/2	1 and 10/26/21 the Director					
		e/Risk Management stated:					
	- Was on vac occurred on 9/25/21	ation during the incident that					
		eviewed the video and felt the					
		been handled differently from					
	the beginning of the b	pehaviors starting. Yould have deescalated that					
		ginning and remove her, that					
	would not have led to						
		n "spiraled" and should have					
	led to the police bein	g called					
	- Did not see the physical aggression from						
	other clients						
	- Police were	called per the direction of the					
		al aggression was from client					
	#1 and no other clier						
		ld her she was called by the					
	House Supervisor tha	at evening saying there was					
	•	und to handle the situation					
	with client #1 - The CFO the	en told the House Supervisor					
	to call the police to he						
	•	peer on peer conflict					
	is"typical" behaviorir						
		code purple," which is for a					
	"combative situation"		(VO) MULTIPLE	CONSTRUCTION	I		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE S COMPL		
			A. BOILDING.			_	
		20140058	B. WING		10/2	26/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STA	TE, ZIP CODE			
STRATEG	3200 WATERFIELD DRIVE STRATEGIC BEHAVIORAL CENTER-GARNER						
J.IMILO	SERVICIAL CENTE	GARNER,	NC 27529			ı	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE	
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI		DATE	
Sintalan af II.	alth Camina Danielatia			DEFICIENCY)			

Division of Health Service Regulat	tion	_		
V 537 Continued From page 1	104	V 537		
- Have been emple never heard that of a "core the police shot this situation - When a client is staff were to observe the door - While watching the 300 hall, not sure whom itoring client #1 whi - Clients should while in the isolation room interview on 10/25/21 the stated: - He had been the Prevention Intervention - Training is ver psychiatric hospital - Staff is to keep is difficult to do when the to do so - The nurses have past to use their training - The staff definition and to intervene - If a client was a should have been contained to the correct amount of staff interview on 10/18/21 & Nursing Officer (CNO) resolved.	ployed for three years and ode brown" being called build not have been called in its in the isolation room, the le client at the window of g the video of 9/25/21 on hy staff was not present lile in the isolation room. If have constant monitoring om the Program Coordinator the trainer for Crisis is (CPI) for the staff by clear that they are a so the clients safe and that the staff was not equipped to the been "reluctant" in the go itely understand their role escalating, the doctor facted regarding the client's are contacted the Police as and led by staff if they had taff on duty.	V 537		
in the isolation room at a	all times			
Interview on 10/25/21 th	ne CEO stated:			
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20140058	B. WING		C <b>10/26/2021</b>
NAME OF PROVIDER OR SUPPLIER  STRATEGIC BEHAVIORAL CENTER-	3200 WATE	RESS, CITY, STATERFIELD DRIV		
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETE

STATE FORM 6899 GGVI11 If continuation sheet 107 of 107

TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETE
		GARNER,		T		
STRATEG	IC BEHAVIORAL CENTE	R-GARNER	RFIELD DRIV	E		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADDR	RESS, CITY, STAT	TE, ZIP CODE		
		20140058	B. WING		10/2	6/2021
			D WING		(	
	OF CORRECTION	IDENTIFICATION NUMBER:	, ,		COMPL	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	ECONSTRUCTION	(X3) DATE S	URVEY
	- Staff #2 had to Restrictive Interver	been trained in Alternatives ntions by the time she would should have engaged in				
	employee working the other staff	at evening alone with one				
		are there was a shadow				
	being harmed by the	girls				
		rious and concerned about				
	as they were trained - After the inc	to do so ident heard that staff working				
		I not respond to the situation				
	responded					
		natmany police had to				
	with the verbal escala					
		rse's station and not deal				
		about how several staff just				
		o was involved that evening od job during the incident				
	done differently	a waa in ya luad that ayar ira				
		ne what could have been				
		ed the video with the staff				
	had been resolved	,				
	_	in thirty minutes and things				
		s were "pretty heightened"				
	prior to calling the Po - Never "Ok" v	vith the police being called				
		d utilized all other options				
	authority to call the po	_				
		s when the staff is giving the				
		Supervisor had used the				
		lice when he called her				
	- The House S	Supervisor stated he had				
	was injured					
		were attacking staff and staff				
	attacking staff and jur	<del>-</del>				
		old her the girls unit was				
		Supervisor called her a little				
	when the incident oc					
	Sho was the	AOC on call on 9/25/21				
V 537	Continued From pag	e 105	V 537			
DIVISION	oi neaith Service Regu	lauon				

Division	Division of Health Service Regulation					
V 537		V 537				
	<ul> <li>While client #1 was in isolation, she should have been in constant observation from the staff</li> <li>The client should have been monitored after the isolation by the nurse and ongoing throughout the night</li> </ul>					
	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.					