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V 000	INITIAL COMMENTS An annual, follow up, and complaint survey was completed on October 20, 2021. The complaint was substantiated (intake #NC00182259). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and	V 105	DHSR-Mental Health NOV 24 2021 Lic. & Cert. Section	

Allison Hamm, NHA
11-18-21

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V 105	Continued From page 1 recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105		

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V 105	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to implement written standards that assured operational and programmatic performance meeting applicable standards of practice for use of restrictive interventions as planned interventions, assessment post seclusion or restraint, and reporting serious occurrences to the State designated Protection and Advocacy system. The findings are: A. Review on 10/6/21 of the Code of Federal Regulations (CFR) revealed -"§483.370(a) Within 24 hours after the use of the restraint or seclusion, staff involved in an emergency safety intervention and the resident must have a face-to-face discussion. This discussion must include all staff involved in the intervention except when the presence of a particular staff person may jeopardize the wellbeing of the resident. Other staff and the resident's parent(s) or legal guardian(s) may participate in the discussion when it is deemed appropriate by the facility..." Reviews between 10/6/21 and 10/20/21 of the facility's North Carolina Incident Response Improvement System (IRIS) reports dated 6/2/21 through 10/20/21 revealed: -6/2/21 client #3 had been placed in a standing restraint and seclusion. -7/2/21 client #1 had been placed in a standing restraint and seclusion with 3 staff involved in the intervention (Staff #11, Registered Nurse (RN) Supervisor #2, and a Teacher). -7/2/21 client #2 had been placed in a standing restraint and seclusion with 3 staff involved in the intervention (Staff #11, Staff #14, RN Supervisor #2).	V 105	All staff involved in the use of restraint or seclusion will participate in patient debriefing completed within 24 hours of the intervention, with the exception of when the presence of a particular staff member may jeopardize the wellbeing of the patient. Patient Debriefing forms were updated to include a designated area for all staff names involved in the restrictive intervention. Forms were implemented on 11/8/21. All direct care staff have been educated and trained on this requirement in their November staff meetings on 11/15/21 and 11/17/21. Ongoing coaching and education will occur following any restrictive intervention. The Director of Risk Management/ Performance Improvement or designee audits 100% of all restrictive interventions on a monthly basis to monitor compliance with staff involvement in patient debriefing. Data analysis will be reported monthly in Patient Safety Council. All reportable occurrences to IRIS and DRNC will include names of all staff directly involved in the incident.	11/17/21 10/21/21 10/21/21

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V 105	Continued From page 3 -7/19/21 client #2 had been placed in a standing restraint and seclusion with 5 staff involved in the intervention (RN Supervisor #4, RN #1, RN #3, RN #5, and Staff #9). -7/24/21 client #1 had been placed in a standing restraint and seclusion with 5 staff involved in the intervention (RN Supervisor #2, RN #3, RN #5, Staff #12, Staff #13). -9/15/21 client #3 had been placed in a standing and face up restrictive interventions with 5 staff involved in the intervention (Staff #10, RN #1, RN Supervisor #4, RN Supervisor #5, RN Supervisor #6). Review on 10/6/21 and 10/11/21 of client #1's record revealed: -7/3/21 debriefing documented Staff #8 was the only staff involved in the post-debriefing for the restrictive intervention that occurred on 7/2/21. (Staff #8 was not listed in IRIS as a person involved in the intervention.) -7/24/21 debriefing documented RN #2 was the only staff involved in the post-debriefing of the restrictive intervention that occurred on 7/24/21. (RN #2 was not listed in IRIS as a person involved in the intervention.) -There was no documented reasons the other staff involved in the restrictive interventions were not present for the debriefings on 7/3/21 or 7/24/21 with client #1. Review on 10/11/21 of client #2's "Physical Intervention - Patient Debriefing" documentation for interventions on 7/2/21 and 7/19/21 revealed: -Debrief dated 7/3/21 documented Staff #8 was the only staff involved in the post-debriefing of the restrictive intervention that occurred on 7/2/21. (Staff #8 was not listed in IRIS as a person involved in the intervention.) -Debrief dated 7/19/21 documented RN #1 was	V 105		

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V 105	Continued From page 4 the only staff involved in the post-debriefing of the restrictive intervention that occurred on 7/19/21. -There was no documented reasons the other staff involved in the restrictive intervention were not present for the debriefings on 7/3/21 or 7/19/21 with client #2. Review on 10/11/21 of client #3's "Physical Intervention - Patient Debriefing" documentation for interventions on 9/15/21 revealed: -Debrief dated 9/15/21 documented RN #6 was the only staff involved in the post-debriefing of the restrictive intervention that occurred on 9/15/21. (RN #6 was not listed in IRIS as a staff involved in the intervention.) -There was no documented reasons the other staff involved in the restrictive intervention were not present for the debriefing on 9/15/21 with client #3. Interview on 10/8/21 Staff #2 stated the client debrief following a restrictive intervention was usually done by 1 staff and the client. Interview on 10/8/21 Staff #1 stated the client debrief was done by the nurse or supervisor. He participated in the staff debrief but never in the client debrief. B. Review on 10/6/21 of the LME-MCO (Local Management Entity-Managed Care Organization) communication Bulletin J287, "Clarifying the Reporting Standards for Psychiatric Residential Treatment Facilities (PRTF)" dated 5/11/18 revealed: -" ...Serious Occurrences are any event that result in Restraint or Seclusion, Resident's Death, Any Serious Injury to a Resident, and a Resident's Suicide Attempt. NC § 483.374 specifies that facilities must report each Serious	V 105	The Director of Risk Management & Performance Improvement or designee will be responsible for submitting all reportable occurrences through the IRIS system and verify submission by printing out the confirmation page. Reports will also be faxed to DRNC by the Director of Risk Management & Performance or designee and will be documented and verified by the fax transmission form. All reports and verifications are filed by date and maintained by the Director of Risk Management/Performance Improvement.	10/21/21

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V 105	Continued From page 5 Occurrence to both the State Medicaid agency (Division of Medical Assistance - DMA) and, unless prohibited by State law, the State-designated Protection and Advocacy system (Disability Rights North Carolina - DRNC)." -"DRNC reports are to be faxed to (919) 856-2244." Review on 10/11/21 of facility reports to the state designated protection and advocacy system revealed: -No report had been submitted for the restrictive interventions of client #1 on 7/24/21. -No report had been submitted for the restrictive interventions of client #3 on 6/2/21.	V 105	The Director of Risk Management & Performance Improvement has been provided with the IRIS reporting manual and has reviewed said manual for training on occurrences that are reportable to both IRIS and DRNC.	10/22/21
	C. Review on 10/6/21 of CFR §483.356(a)(2) revealed: -"An order for restraint or seclusion must not be written as a standing order or on an as-needed basis." Review on 10/6/21 and 10/11/21 of client #1's record revealed: -"Crisis Prevention and Intervention Plan" dated 7/15/21, "Strategies for crisis response and stabilization" read, "In the event of imminent danger ... the use of restrictive intervention will be used..." Interview on 10/11/21 Director of Risk Management stated: -She was unable to confirm transmission of facility reports to the state designated protection and advocacy system for restrictive interventions administered on 6/2/21 for client #3 and 7/24/21 for client #1. -She was aware restrictive interventions were not		Brynn Marr Hospital does not employ the use of a standing order for restraint and seclusion. All physician orders for restrictive interventions are obtained within 30 minutes of the intervention and are only utilized when other least restrictive interventions have failed and in the event of imminent risk of harm to self or others. The Crisis Prevention and Intervention Plan for Client #1 has been amended to remove the language stating that the use of restrictive interventions are used on an as-needed basis. All PRTF Clinical staff have been educated on this standard, and attended a training on 11/3/21 facilitated by the Director of Clinical Services and Clinical Services Manager on the treatment planning policy and process.	10/21/21 11/12/21 11/3/21

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V 105	Continued From page 6 to be a part of a client treatment plan and would follow up on client #1's plan. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 105		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112	The Clinical Services Director and Nurse Managers conducted an audit of 100% of all current PRTF patient medical records to verify proper assessment of all high-risk behaviors and corresponding precautions to inform treatment goals and interventions. All PRTF therapists were provided with individual re-education on 10/22/21 regarding this standard of care, and treatment plans were updated as needed to reflect all identified high-risk behaviors. PRTF therapists attended and completed a training on the treatment planning process and policy facilitated by the Director of Clinical Services and Clinical Services Manager. Direct care staff to include Intake, Nursing, Mental Health Technicians, Therapeutic Intervention Coordinators, PRTF Therapists, Recreational Therapists, and teachers reviewed facility policy on Patient Precautions/ Restriction Level and Levels of Observation and signed an attestation acknowledging review and understanding of the policies.	10/22/21 11/3/21 11/12/21

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V 112	Continued From page 7 This Rule is not met as evidenced by: Based on record review and interview the facility failed to develop and implement strategies based on assessment for 1 of 6 audited clients (#4). The findings are: Review on 10/15/21 and 10/18/21 of client #4's record revealed: -17 year old female admitted 6/10/21. -Discharged 10/13/21 as a result of client #4's elopement from the facility on 10/12/21. -Diagnoses included disruptive mood dysregulation disorder; post-traumatic stress disorder; conduct disorder, adolescent onset type; cannabis use disorder; sedative, hypnotic or anxiolytic use disorder. -Client #4 was a voluntary admission due to increased aggression, suicide attempts and false accusation of sexual assault by a family member. -Client #4 had a history of multiple elopements from home with the most recent having been 1 month prior to admission. -6/10/21: Nursing Admission Assessment (check list format) documented "Substance abuse" to be an elopement risk factor, but did not select "History of elopement" to be a risk factor. -6/11/21: Psychosocial Assessment quoted client #4, "I feel like I have a lack of communication with my mother. I don't feel like I can control my impulses." -6/11/21: Psychiatrist Admission History documented client #4's mood lability going between "really irritable to really happy...," physical aggression, periods of elevated mood, and increased risk taking behaviors such as running away. -6/24/21: Neuropsychiatric Evaluation documented client #4 told her mother of sexual	V 112		

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V 112	Continued From page 8 abuse by a family member in March 2021, had made suicide attempts in March and April 2021, had been "running away" because her mother had taken the client's phone and client #4 was trying to get away from the accused family member. -Neuropsychiatric Evaluation (dated 6/24/21) Treatment recommendations included individual therapy focused on impulsive decision making, need to elope, and substance use. Review on 10/15/21 of client #4's treatment plan signed 7/8/21 revealed: -Goals and strategies included client #4 would identify triggers/stressors /underlying causes of her suicide attempts; participate in cognitive behavioral therapy to learn how to manage her depressed mood; implement new methods of effective communication and problem solving between family members. -There were no goals or strategies to address elopement behavior, aggressive behavior, or substance use. Review on 10/15/21 and 10/18/21 of client #4's "Master Treatment Plan Update/Clinical Staffing Worksheet dated 9/30/21 revealed: -Tentative discharge date, 11/18/21. -"[Client #4] presents with a fluctuating/labile mood and is making minor progress towards her treatment goals." -9/19/21 client #4 "attempted to encourage a peer to attack a peer on her behalf." -9/23/21 client #4 "used selective peers medication." -"On the unit, [client #4] requires frequent redirection AEB (as evidenced by) her poor boundaries with a select peers, instigating, and writing letters to peers encouraging them to partake in breaking rules. She is reported to be manipulative at times AEB: encouraging peers to	V 112		

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V 112	Continued From page 9	V 112		

seek medication on her behalf, encourage peers to fight, encouraging peers to not follow direction ... [Client #4] has engaged in aggression AEB: attacking a peer on the unit causing physical injuries."

Review on 10/18/21 of the facility's incident reports from 7/1/21 through 10/18/21 revealed:
-9/11/21 client #4 "jumped" a peer, began kicking the peer lying on the floor, kicking staff, and was placed in a 2 person physical restraint.
-9/18/21 client #4 got into a "physical confrontation" and kicked client #5 in the upper right cheek and eye. Client #5 was seen in the emergency room and diagnosed with a corneal abrasion of the right eye.
-10/12/21 client #4 and client #5 had assaulted Staff #3 and eloped.

Reviews on 10/18/21 - 10/20/21 of the facility's internal Investigation Summary dated 10/13/21 revealed:
-On 10/12/21 at 8:29 pm client #4 and client #5 assaulted Staff #3, took the staff's keys, and exited the facility through a courtyard.
-Interviews with other clients on 10/13/21 documented:
-Client #6 and client #2 had heard client #4 and client #5 talking about a plan to elope about 1 month ago.
-Client #1 had heard client #4 and client #5 talking about a plan to elope about 2 weeks prior to the incident.

Interview on 10/15/21 Nursing Supervisor #2 stated client #4 was not considered to be an elopement risk.

Interview on 10/15/21 Nursing Supervisor #4 stated:

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V 112	Continued From page 10 -Client #4 did not have a history of elopement. -The plan was to discharge client #4 "in the near future." -Client #4 was upset about her upcoming discharge when she would have to return home to live with the family member she had accused of rape. Client #4 was "stressing" because her mother took the family member's "side" and she felt she had no one to support her. This deficiency is cross referenced into 10A NCAC 27G .1901 Scope (V314) for a Type A1 and must be corrected within 23 days.	V 112		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to hold disaster drills or fire drills that simulated fire emergencies, at least quarterly on	V 114		

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V 114	Continued From page 11 each shift. The findings are: Interview on 10/6/21 the Chief Nursing Officer stated there were 2 shifts, 7 am - 7 pm, and 7 pm - 7 am. Review on 10/6/21 of the facility fire and disaster drills from 10/1/20 - 9/30/21 revealed: -No fire drill documented on the 7 am - 7 pm shift between 1/1/21 - 3/31/21. -There was 1 disaster drill documented 5/25/21. Interview on 10/7/21 the Plant Operations Manager stated: -One of his responsibilities was to coordinate emergency plans. -On the night shift, 7 pm - 7 am, the fire drills documented were "silent" fire drills. -A "silent" fire drill did not include a practice of client evacuation. -He had not understood that disaster and fire drills were not one in the same. -The facility followed the requirements of the facility's national accrediting body that required 2 disaster drills a year. -The facility was counting the facility's response to the coronavirus pandemic as 1 disaster drill. -In addition to the coronavirus pandemic, the most recent disaster drill was held 5/25/21. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 114	The Director of Plant Operations or designee will conduct a minimum of 2 fire drills and 2 disaster drills time per shift per quarter as required. The 7pm-7am shift drills will no longer be silent and shall include the practice of patient evacuation to simulate a fire emergency. Both a fire drill and disaster (tornado) drill were conducted on 10/21/21. Evidence of drills are reported quarterly in Environment of Care meetings by the Director of Plant Operations to ensure compliance.	10/21/21
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be	V 123		

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V 123	Continued From page 12 reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted. . This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure medication errors were reported immediately to a physician or pharmacist and refusals charted affecting 3 of 3 clients audited (#1, #2, #3). The findings are: Finding #1: Review on 10/6/21 of client #1's record revealed a 15 year old female admitted 4/24/21 with diagnoses that included major depressive disorder, recurrent; anxiety; post traumatic stress disorder (PTSD); attention deficit hyperactive disorder (ADHD); schizo-affective disorder. Reviews between 10/6/21 and 10/11/21 of client #1's Medication Administration Records (MARs) for 7/1/21-9/30/21 revealed the following medications documented "NA": -Paliperidone ER (extended release) 6 mg (milligrams) on 7/1/21 and 7/2/21 at 9 pm. (Antipsychotic) -Lithium ER 450 mg on 8/1/21 at 5 pm. (Mood Stabilizer) -Depakote ER 500 mg on 8/1/21 at 5 pm. (Mood Stabilizer) -Cyclobenzaprine 5 mg on 9/28/21 and 9/29/21 at 7 pm. (Antidepressant)	V 123	The Chief Nursing Officer and Nurse Managers provided re-education during Nursing staff meetings on 10/18/21, 10/20/21, 11/15/21, and 11/17/21 regarding the policy and practice of ensuring medication errors are reported to a physician or pharmacist immediately and medication refusals are charted. Nurses were instructed to document in the daily nursing progress note and the electronic medical record (HCS). Nursing leadership will begin auditing a random sample of patients refusing medication on a monthly basis and report findings in Quality Council and Medical Executive meetings. Data will include compliance with proper documentation and physician notification of patient medication refusals.	12/1/21

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V 123	Continued From page 13 -Flonase 5 mcg (micrograms) nasal spray was documented as "NA" for 66 doses between 7/1/21 and 9/30/21. (Allergy Symptoms) -Lactase 3,000 units was documented as "NA" for 74 doses between 7/1/21 and 9/30/21. (Lactose Intolerance) Finding #2: Review on 10/8/21 of client #2's record revealed a 16 year old female admitted 10/17/20 with diagnoses that included bipolar 1 disorder, and ADHD. Reviews between 10/8/21 and 10/11/21 of client #2's MARs for 7/1/21-9/30/21 revealed the following medications documented, "NA." -Aripiprazole 15 mg on 7/18/21 at 9 am. (Mental/mood disorders) -Benztropine 1 mg on 7/18/21, 7/27/21, 7/31/21 at 9 am; and, 8/1/21 at 5 pm. (Involuntary movements) -Clozapine 25 mg on 7/14/21 at 9 pm. (Antipsychotic) -Clozapine 150 mg on 7/19/21 at 9 pm. -Clozapine 300 mg on 7/125/21 at 9 pm. -Depakote ER 1250 mg on 7/14/21, 8/20/21, and 8/21/21. -Docusate 100 mg on 7/31/21 and 8/23/21 at 9 am; 8/25/21 and 8/26/21 at 5 pm; 8/1/21, 8/21/21, and 8/22/21 at 9 am and 5 pm. (Constipation) -Ethnyl at 9 am on 7/8/21, 7/27/21, 7/31/21, 8/1/21, 9/4/21-9/6/21, 9/8/21-9/18/21. -Eucerin Cream scheduled applications were documented "NA" for 48 of 62 doses in July 2021, 44 of 62 doses in August 2021, and 57 of 60 doses in September 2021. (Dry skin) -Guanfacine 4 mg on 7/18/21, 7/27/21, 7/31/21 at 9 am. (ADHD) -Hydroxyzine 50 mg on 7/12/21, 7/13/21, 7/21/21, and 8/1/21 at 1 pm; 7/18/21, 7/27, and 7/31/21 at	V 123		

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V 123	Continued From page 14 9 am; and 8/1/21 at 5 pm. (Mental/Mood disorders) -Loratadine 10 mg on 7/18/21, 7/27/21, and 7/31/21 at 9 am. (Allergy symptoms) -Oxcarbazepine 300 mg on 7/18/21, 7/27/21, and 7/31/21 at 9 am; 7/12/21, 7/13/21, 7/21/21, and 8/1/21 at 1 pm; and, 8/1/21 at 5 pm. (Mood stabilizer) -Clotrimazole topical 1% cream was documented "NA" for 26 of 28 scheduled applications between 9/1/21 and 9/14/21. (Antifungal) -Metformin 500 mg on 7/27/21, 7/31/21, and 8/1/21 at 9 am; 7/17/21 and 8/1/21 at 5 pm. (Appetite suppressant) Finding #3: Review on 10/8/21 of client #3's record revealed a 15 year old female admitted 1/12/21 with diagnoses of disruptive mood Dysregulation disorder, pre-diabetes, obesity, and bipolar disorder. Reviews between 10/8/21 and 10/11/21 of client #3's MARs for 7/1/21-9/30/21 revealed the following medications documented, "NA." -Eucerin Cream was documented "NA" for 152 scheduled applications between 7/01/21 and 9/30/21. -Duloxetine DR 60 mg on 7/03/21, 7/13/21, 7/17/21, 7/21/21, 7/23/21, 7/26/21, 8/01/21, 8/09/21, 8/14/21, 8/15/21, 9/16/21, 9/21/21, and 9/25/21 at 9:00am. (Antidepressant) -Duloxetine DR (delayed release) 30 mg, 7/03/21, 7/13/21, 7/17/21,7/21/21, 7/23/21, 7/26/21 at 9:00am -Metformin 500 mg on 7/03/21, 7/13/21, 7/17/21, 7/21/21, 7/23/21, 7/26/21, 8/01/21, 8/09/21, 8/14/21, 8/15/21, 9/16/21, 9/21/21, and 9/25/21 at 9:00am. -Melatonin 6 mg on 7/02/21 T 9:00pm. (Sleep aid)	V 123		

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V 123	Continued From page 15 -Thorazine 300 mg, 8/02/21 at 9:00pm. (Antipsychotic) -Thorazine 100 mg on 7/03/21, 7/17/21, 7/21/21, 7/23/21, 7/26/21, 8/01/21, 8/09/21, 8/14/21, and 8/15/21 at 9:00am; 7/05/21 and 8/09/21 at 1:00pm. -Thorazine 50 mg on 7/05/21 and 7/12/21 at 1:00pm; and 7/09/21, 7/13/21, and 9/17/21 at 9:00am. -Cogentin (Benztropine) 1 mg on 7/03/21, 7/13/21, and 7/17/21 at 9:00am. (Tremors) -Cogentin 0.5 mg on 7/21/21, 7/23/21, and 7/26/21 at 9:00am. -Abilify (Aripiprazole) 5 mg on 9/16/21 at 9:00am. (Bipolar disorder) -Abilify 10 mg on 9/21/21 and 9/25/21 at 9:00am. -Topamax 200 mg on 9/15/21 at 9:00pm. (Bipolar disorder) Review on 10/8/21 of the facility policy, "Medication Administration" dated 8/12/21 revealed: -Policy for late, refused, or withheld doses read, "Notify the provider if medication is late, withheld, or refused." -Policy did not include directions to document medications not administered in a way that would differentiate refusals from other reasons medications were not given. Interview on 10/8/21 the Pharmacist stated "NA" on the MARs meant the medication was "not administered." Interview on 10/8/21 the Registered Nurse #3 stated: -When a client refused their medications she would try to "educate" them. -She would not call the provider to report refusals. -The majority of medications refused were	V 123	The Chief Nursing Officer will conduct a review of the facility's Medication Administration policy to determine if changes are necessary to accurately reflect how staff document medications not administered. Nursing staff to be trained on any changes made to the policy following policy approval by Medical Executive Committee and Board of Governors.	11/19/21

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V 123	Continued From page 16 Eucerin cream and Flonase. Interview on 10/8/21 the Director of Nursing stated: -She could not identify what the MAR acronym "NA" stood for. -"NA" would be used to document medication refusals. -The nurses were not required to call a provider or pharmacist when a client refused a medication. -The providers were on site daily and had access to the electronic MARs.	V 123		
V 314	27G .1901 Psych Res. Tx. Facility - Scope 10A NCAC 27G .1901 SCOPE (a) The rules in this Section apply to psychiatric residential treatment facilities (PRTF)s. (b) A PRTF is one that provides care for children or adolescents who have mental illness or substance abuse/dependency in a non-acute inpatient setting. (c) The PRTF shall provide a structured living environment for children or adolescents who do not meet criteria for acute inpatient care, but do require supervision and specialized interventions on a 24-hour basis. (d) Therapeutic interventions shall address functional deficits associated with the child or adolescent's diagnosis and include psychiatric treatment and specialized substance abuse and mental health therapeutic care. These therapeutic interventions and services shall be designed to address the treatment needs necessary to facilitate a move to a less intensive community setting. (e) The PRTF shall serve children or adolescents for whom removal from home or a community-based residential setting is essential	V 314		

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V 314	Continued From page 17 to facilitate treatment. (f) The PRTF shall coordinate with other individuals and agencies within the child or adolescent's catchment area. (g) The PRTF shall be accredited through one of the following; Joint Commission on Accreditation of Healthcare Organizations; the Commission on Accreditation of Rehabilitation Facilities; the Council on. Accreditation or other national accrediting bodies as set forth in the Division of Medical Assistance Clinical Policy Number 8D-1, Psychiatric Residential Treatment Facility, including subsequent amendments and editions. A copy of Clinical Policy Number 8D-1 is available at no cost from the Division of Medical Assistance website at http://www.dhhs.state.nc.us/dma/. This Rule is not met as evidenced by: Based on record reviews, observations, and interviews, the facility failed to provide a structured living environment to meet the supervision needs for 2 of 6 clients audited (client #4 and #5). The findings are: Cross Reference: 10A NCAC 27G .0205 ASSESSMENT AND TEATMENT/HABILITATION OR SERVICE PLAN (V112) Based on record reviews and interviews the facility failed to develop and implement strategies based on assessment for 1 of 6 audited clients (#4). Cross Reference: 10A NCAC 27G .1901 STAFF (V315) Based on record reviews and interviews, the facility failed to ensure at least 2 direct care	V 314		

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V 314	Continued From page 18 staff were present with every 6 children or adolescents at all times. The findings are: Review on 10/20/21 of the Plan of Protection dated 10/20/21 signed by the Director of Clinical Services revealed: -"What immediate action will the facility take to ensure the safety of the consumer's in your care? 10/13/2021 a memo was posted to 1 East nursing station indicating that the practice of taking patients off Unit for restroom use was to be discontinued immediately. Memo also indicated that 1 East patients were to use an interior courtyard with all staff present. An additional memo will be posted on 10/20/2021 to unit nursing station. Memo to indicate a minimum of 2 direct care staff members present at all times with patients. Additionally information to be shared via shift hound, shift report and email to staff members responsible for patient care. Nursing leaders will communicate with all 1 East staff per shift for the next 7 days face to face as noted above. All high risk behaviors will be assessed and included in treatment plan." -"Describe your plans to make sure the above happens. Verify that all nurse leaders are communicating the above mentioned through the use of a signature log of all staff that are educated. Nursing Supervisors to monitor staff to patient compliance ratios one time per shift. This will be documented. During morning flash meetings, senior leadership will complete random video reviews. This will be reviewed daily (business days) for the next 2 weeks. Information to be shared with CEO (Chief Executive Officer). 100% of all PRTF (psychiatric residential treatment facility) patients treatment plan will be audited for inclusion of high risk behavior." Client #4 was a 17 year-old female admitted	V 314	A memo was posted on the PRTF unit indicating 2 direct care staff members will be present with up to 6 patients at all times. This information was disseminated via Shifthound and email as well as verbally via shift report and individually by Nurse Leaders. Direct care staff signed an attestation verifying they had been educated on the staff to patient ratio requirements. The Clinical Services Director and Nurse Managers conducted a review of 100% of all current PRTF patient medical records to verify proper assessment of all high-risk behaviors and corresponding precautions to inform treatment goals and interventions. All PRTF therapists were provided with individual re-education on 10/22/21 regarding this standard of care. PRTF therapists attended and completed a training on treatment planning facilitated by the Director of Clinical Services and Clinical Services Manager. Nursing Supervisors review and monitor compliance with staff to patient ratio at least once per shift. Director of Risk Management/ Performance Improvement conducted random camera audits between 10/21/21 and 11/5/21 to ensure proper staff to patient ratio was maintained at all times. All findings were compliant and shared with the CEO and leadership team.	10/20/21 10/22/21 11/3/21 Ongoing 11/5/21

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V 314	Continued From page 19 6/10/21 with diagnoses of Post-Traumatic Stress Disorder (PTSD), Disruptive Mood Dysregulation Disorder, and Major Depressive Disorder. Client #5 was a 17 year-old female admitted 8/10/21 with diagnoses of Attention Deficit Hyperactivity Disorder (ADHD), Bipolar Disorder Unspecified, and Cannabis Use Unspecified. Client #4 had a history of elopement which had not been documented on her current treatment plan or patient observation record. Client #4 also had a history of assault, including an assault on client #5 which resulted in medical treatment by a local hospital on 9/18/21. Due to inappropriate activity in the bathrooms on the 1E (East) unit, a verbal directive was issued on 9/23/21 to escort clients by groups off the unit to use the educational hall restroom. In the following weeks the verbal order expanded to include a 9:00pm curfew and a staff ratio of 1 staff per 3 clients. The verbal orders were passed between staff on the 1E unit and the point of origin was not identified. On 10/12/21, at approximately 8:30pm, staff #3 conferred with staff #6 and RN #4 prior to escorting clients #4 and #5, and #6 to the adjacent administrative hall. While transitioning to the administrative hall, client #6 was stopped from leaving the 1E unit due to an observation protocol following medication consumption and remained behind on the 1E unit. Staff #3 continued to the administrative hall with clients #4 and #5. Once the group reached the end of the administrative hall, staff #3 was placed in a chokehold by client #5 and the facility keys were taken from her by client #4. The facility keys were used to exit the facility and gain access to a court yard and parking lot where clients #4 and #5 fled on foot. Shortly following the elopement, two girls fitting the description of clients #4 and #5 were	V 314	Direct care staff to include Intake, Nursing, Mental Health Technicians, Therapeutic Intervention Coordinators, PRTF Therapists, Recreational Therapists, and teachers reviewed facility policy on Patient Precautions/ Restriction Level and Levels of Observation and signed an attestation acknowledging review and understanding of the policies. Administrators on Call conduct weekly in-person audits and camera reviews across multiple shifts to monitor compliance with the facility Patient Observation policy. Findings that are out of compliance are reported to the direct supervisor. Aggregate data is analyzed and reported monthly in Patient Safety Council by the Director of Risk Management/ Performance Improvement.	11/12/21 ongoing

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V 314	Continued From page 20 identified in the theft of a vehicle at a nearby gas station. Clients #4 and #5 had not been located as of 10/20/21. Following the elopement, the facility restricted bathroom use to the 1E unit, but staff continued to escort multiple clients off the unit in a ratio of one staff up to three clients. Failure to meet the supervision and treatment planning needs of two clients resulted in the assault of staff #3 and the serious neglect of clients #4 and #5 with their elopement from the facility. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $3,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 314		
V 315	27G .1902 Psych. Res. Tx. Facility - Staff 10A NCAC 27G .1902 STAFF (a) Each facility shall be under the direction a physician board-eligible or certified in child psychiatry or a general psychiatrist with experience in the treatment of children and adolescents with mental illness. (b) At all times, at least two direct care staff members shall be present with every six children or adolescents in each residential unit. (c) If the PRTF is hospital based, staff shall be specifically assigned to this facility, with responsibilities separate from those performed on an acute medical unit or other residential units. (d) A psychiatrist shall provide weekly consultation to review medications with each child or adolescent admitted to the facility.	V 315		

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V 315	Continued From page 21 (e) The PRTF shall provide 24 hour on-site coverage by a registered nurse. This Rule is not met as evidenced by: Based on record reviews, observations, and interviews, the facility failed to ensure at least 2 direct care staff were present with every 6 children or adolescents at all times. The findings are: Review on 10/15/21 - 10/18/21 of client #4's record revealed: -17 year-old female. -Admission date of 6/10/21. -Diagnoses of Post-Traumatic Stress Disorder (PTSD), Disruptive Mood Dysregulation Disorder, and Major Depressive Disorder. -History of elopement. -Discharged 10/13/21 due to an elopement from facility. Review on 10/15/21 - 10/18/21 of client #5's record revealed: -17 year-old female. -Admission date of 8/10/21. -Diagnoses of Attention Deficit Hyperactivity Disorder (ADHD), Bipolar Disorder- Unspecified, Cannabis Use-Unspecified. -Discharged 10/13/21 due to an elopement from facility. Review on 10/18/21 of staff #3's personnel record revealed: -Date of hire: 9/13/21. -Position Description: Mental Health Technician	V 315	Nursing Leaders to ensure the unit maintains a 2 to 6 staff to patient ratio at all times. The Chief Nursing Officer, Nurse Leaders, and/or Staff Coordinator review the unit schedule at a minimum of 3 times per shift to verify staff to patient ratio. Director of Risk Management/ Performance Improvement conducted random camera audits between 10/21/21 and 11/5/21 to ensure proper staff to patient ratio was maintained at all times. All findings were compliant. Administrators on Call conduct weekly in-person audits and camera reviews to ensure Patient Observation policy is followed at all times. Findings that are out of compliance are reported to the direct supervisor. Aggregate data is analyzed and reported monthly in Patient Safety Council by the Director of Risk Management/ Performance Improvement.	10/20/21 11/5/21 ongoing

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V 315	Continued From page 22 (MHT). Review on 10/18/21- 10/19/21 of facility's internal investigation dated 10/13/21 revealed: -Camera Review Notes: "8:27pm MHT [staff #3] leaves the group room with patients [client #5], [client #4], and [client #6] and all 4 begin to walk down the hallway...8:28pm [Client #6] can be seen stopping in the middle of the hallway, turning around, and returning to the group room. MHT [staff #3] appears to say something to [client #6], then continues walking down the hallway with [client #5] and [client #4] behind her as they exit the 1 East (E) door onto the Administrative hallway...8:29pm [Staff #3] is attacked by [client #4] and [client #5] from behind around her neck while she is trying to open the door leading into the sublobby with her keys. It appears that [client #4] attacked MHT [staff #3] around the neck area first, then [client #5] holds the MHT while [client #4] takes her keys. [Client #4] runs back down the hallway towards the exterior door with MHT [staff #3]'s keys, then [client #5] runs after her. MHT [staff #3] composes herself within seconds and runs after them, stopping to pick up something from the floor (unknown what the items is she picks up)...8:29.38 [Client #4] uses MHT [staff #3]'s keys to unlock the exterior door. [Client #4] and [client #5] exit the door. " -Administrator on Call Report: "Met with [staff #3]. Per [staff #3], the following occurred: She left the unit with [client #4] and [client #5] to escort them to the restroom in the school hallway due to patients taking showers in their bathrooms. After leaving the unit with the girls, she reports having been attacked from behind by [client #5] as they approached the second locked door. She stated [client #5] put her 'in a headlock.' At this time [client #4] grabbed her blue key ring in an attempt to steal her keys. The ring broke leaving the keys	V 315		

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V 315	Continued From page 23 in [staff #3] MHT's hand. [Client #5] noticed the broken key ring and keys still in [staff #3]'s hand, at which time she began to choke her harder while [client #4] reached for the keys. Once the girls obtained the keys, both girls ran down the hallway and exited out to the gazebo courtyard. [Staff #3] ran to the unit door yelling for staff to call a code E." -1 East Interview on October 13, 2021: "[Client #6] at 1405 (2:05pm) - when asked if she knew anything about the incident [client #6] said 'yeah, I was supposed to go too.' [Client #6] said she knew about it for a month but too afraid to tell anyone. When asked what [client #4] and [client #5] were talking about she said 'they were talking about running away to FL (Florida) or NJ (New Jersey). They talked about selling their bodies to make money. They were going to wait until shower time then choke a staff. They talked about hiding in a yard until they could steal a car. They said they were going to call ex-boyfriends to help them. [Client #5] talked about [unknown] or an active duty guy. [Client #4] had an ex-boyfriend she was going to try to call. When asked about her going with them she said he had just took her night meds and had to stay in the lounge so she couldn't go. [Client #6] said she is glad she didn't go.....[Client #2] at 1425 (2:25pm) - when asked if she knew anything about the incident [client #2] said she heard them talking about jumping the fence in the courtyard with the gazebo for the past month but didn't think they would do anything...[Client #1] at 1430 (2:30pm) - when asked if she knew anything about the incident [client #1] said she heard them talking 2 weeks ago about busting out a bedroom window then running to Topsail, Charlotte or Florida." Review on 10/18/21 of a North Carolina Incident Response Improvement System (IRIS) report	V 315		

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V 315	Continued From page 24 completed by the facility for client #5 revealed: -Date of Incident: 10/12/21. -Time of incident: 8:30pm. -Incident Comments: "[client #5] and another consumer assaulted a staff member, took her keys, and eloped from the facility using the staff member's keys. Patients were last seen stealing a car from a convenience store 1 block from the facility. A BOLO (be on lookout) has been issued for all of Eastern US. Patients are considered missing at the time of this report." -Cause of Incident: "A Mental Health Technician was attacked from behind by 2 patients while escorting them to a patient bathroom. The patients placed the MHT in a chokehold and took her keys from her and used them to elope from the facility. Upon search of patient belongings, a premeditated plan was found in both patients' journal." -Incident Prevention: "The MHT could have requested a second staff member assist her or only taken 1 patient to the restroom at a time." Observation on 10/15/21 at approximately 2:45pm of the hallway where incident occurred revealed: -Exiting the 1E unit required inserting a key into a wall adjacent to wood double doors. The doors were each approximately 48" in width and had a small pane of glass on each door that was approximately 4-5" width and 36" in height providing approximately 10' of visibility into the corner of the administrative hallway. -Upon entering the administrative hallway there was a metal door that exited to a courtyard to the right and doors to the left. -Approximately 10' from the 1E doors was a second hallway that extended around a corner and to the left. -The second hallway was approximately 80' in	V 315		

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V 315	Continued From page 25 length and was connected to a common area by a second locked door. -The second locked door, connecting the common area to the administrative hallway, was a single wood door approximately 48" in width with a small windowpane for visibility into the common area. -No staff were observed during tour of the administrative hallway with visibility and vocalizations limited by layout of the hall. Interview on 10/18/21 staff #3 stated: -She was working on 1E unit the night of the incident 10/12/21. -She had been working at the facility for approximately 30 days. -She was approached by client #4 and client #5 to use the restroom. -She learned from a lead technician that clients were not allowed to use the restrooms on the 1E unit due to inappropriate conduct in the showers, and were being taken off the unit to the school bathrooms. -Staff ratio was up to 3 clients per 1 staff. -She notified staff #6 and Registered Nurse (RN) #4 of her intent to take clients #4, #5, and #6 off the unit to use the restroom and received approval. -Client #6 was not allowed to go with the group due to a required observation following medication consumption. -She felt "uneasy" taking clients #4 and #5 back by herself but trusted lead staff to let her know if this was not an approved practice. -She escorted client #4 and client #5 off the 1E unit and down the administrative hallway. -As she approached the second door at the end of the administrative hall, she was placed in a chokehold by client #5. -As client #5 maintained the chokehold, client #4	V 315		

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V 315	Continued From page 26 then attempted to take her keys but was unable to gain access to the keys. -Client #5 then applied additional pressure to the chokehold and she asked "If I give you the keys will you let me go?" -Client #4 and client #5 stated they would release her if she gave up the keys which she did. -She ran to the 1E unit door and banged on the door to notify other staff of the elopement. Interview on 10/18/21 RN #4 stated: -She was working on 1E unit the night of the incident 10/12/21. -On 9/23/21 the directive was given for 1E unit to begin using the restrooms off the unit due to the "cheeking" of medications. -At some point between 9/23/21 -9/30/21 the directive changed to using the school bathrooms until 9:00pm. -She originally understood that staff were to escort clients off the unit in groups. -At some point the protocol to escort clients off the units in groups changed to a ratio of 3 clients per 1 staff. -She could not recall where she had learned of the protocols and changes, as they were verbalized to her from other staff working the unit. -She had viewed a memo posted on the back of the 1E door at one point that stated the clients were to be escorted off the unit up until 9:00pm, but the memo did not include details for the process. - Staff #3 approached her on 10/12/21 to notify her of the intent to take clients #4, #5, and #6 off the unit to use the restroom. -She understood that staff #3 had notified other staff working the unit of her intent to take clients #4, #5, and #6 off the unit to use the restroom. -She informed staff #3 that client #6 had just taken medications and could not use the	V 315		

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V 315	Continued From page 27 restroom off the unit due to further observation. -Staff #3 was a newer staff person working with other staff who were not typically working that unit on the evening of 10/12/21. -She had not witnessed 1 staff escort more than 1 client off the unit prior to the evening of the elopement. -She learned of the elopement through an elopement code using the intercom system. -The 1E unit no longer takes the girls off the unit to use the restroom. -A new memo dated 10/14/21 was posted on the back of the 1E door stating that all patients were to use the unit bathrooms effective immediately. Interview on 10/18/21 staff #5 stated: -She was on 1E unit the night of the incident 10/12/21. -She normally worked day shift and was not familiar with the nightly routine for the 1E unit. -Staff ratio was up to 3 clients per 1 staff. -She had accompanied 2 clients by herself that day off the unit and had not seen staff working the administrative hall (10/18/21). -She would not have taken client #4 and client #5 off the unit to use the bathroom that evening by herself, as she felt they could have waited. -She had never taken any of the clients from unit 1E to a restroom off the unit by herself. She had always completed this task in tandem with another staff and it was always in the afternoon when there were more people around. -She was taught to always keep the clients to the side of her so that she could properly observe them. -She witnessed client #5 ask staff #3 if she could use the restroom with client #4 and client #6. Client #6 then had to remain behind, and it was just the two clients. -She does not recall body positioning of clients to	V 315		

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V 315	Continued From page 28	V 315		

staff when they exited the unit.
-She did not realize anything was wrong until staff #3 returned to the unit and began banging on door.
-She had observed a memo in the nurses station since the incident detailing how clients could no longer be taken off the unit to use the bathroom.

Interview on 10/15/21 RN Supervisor #2 stated:
-Due to clients on the 1E unit locking themselves in their rooms and participating in inappropriate conduct during times of showering, they were discouraged from entering their rooms until approximately 9:00pm in the evening.
-Staff ratio was up to 3 clients per 1 staff.
-With the exception of a client who was on protocol, staff could escort 2 clients by themselves.
-The girls had detailed plans for their elopement in their journals.
-Neither one of the girls was under elopement protocol at the time of the elopement.

Interview on 10/15/21 RN Supervisor #4 stated:
-He was the on-call RN supervisor on the evening of 10/12/21.
-He heard a Code E called, suggesting a possible elopement, and responded to the appropriate unit.
-He was informed that clients #4, #5, and #6 had requested to use the restroom.
-Staff #3 notified RN #4 and another MHT of her intent to take the 3 clients off the unit to use the restroom.
-Client #6 had recently taken medication and was unable to go off unit with the group and had to remain behind.
-Staff #3 then escorted client #4 and client #5 off the 1E unit and down the administrative hallway.
-Staff #3 was able to get her key into the lock, to

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V 315	Continued From page 29 exit the administrative hallway, when she was placed in a chokehold by client #5. -As client #5 maintained a chokehold, client #4 then attempted to take staff #3's keys but was unable to gain access to the keys. -Client #5 then applied additional pressure to the chokehold and staff #3 asked "If I give you the keys will you let me go?" -Client #4 and client #5 stated they would release staff #3 if she gave up the keys and the keys were then released by staff #3. -He was not certain what the staffing ratio was for the 1E unit at night. -He had previously seen larger groups escorted off the unit but could not recall ever seeing one staff take multiple clients off the unit by themselves. That was "not normally the process we use." -He was not aware of a prior elopement history with client #4 or client #5. -Client #4 had expressed concerns with returning home and was nervous about upcoming discharge. Interview on 10/15/21 Director of Intake and Admissions stated: -She was notified by RN Supervisor on-call at 8:25pm on 10/12/21 of an elopement from the facility involving two adolescent girls. -Staff #3 stated in interview that she was accompanying two clients to a bathroom off the unit, as there had been inappropriate behaviors in the showers on the unit. Due to the recent inappropriate behaviors in the showers, clients on the 1E unit were being escorted to bathrooms off the unit. -Staff #3 escorted two clients off the first unit to a second area. -One of the clients then choked staff #3 while the second client attempted to take staff keys and	V 315		

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V 315	Continued From page 30 run. -Following a failed attempt to gain control of staff #3's keys, a second set of keys was observed in staff #3's hand and the choke was applied with more force. -Staff #3 asked the clients "If I give you the keys will you not hurt me?" -The clients agreed to the request not to hurt staff #3 if she gave them the keys and staff #3 released her grip on a second set of keys. -The two clients then fled from the facility grounds on foot before stealing a car at a local convenience store. -She attempted to locate the keys to the facility but had been unsuccessful in locating the keys. Interview on 10/18/21 Director of Risk Management stated: -A team meeting resulted from the elopement on 10/12/21. -As a result of the team meeting, protocol was changed so that clients on 1E unit were given an opportunity to use the restroom prior to hygiene. -Clients were no longer allowed to be removed from the 1E unit to adjacent units for purposes of using the restroom. This deficiency is cross referenced into 10A NCAC 27G .1901 Scope (V314) for a Type A1 and must be corrected within 23 days.	V 315		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies	V 366		

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V 366	Continued From page 31 shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team;	V 366		

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V 366	Continued From page 32 (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if	V 366		

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V 366	Continued From page 33 different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law.	V 366		
	This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement written policies for reporting/response to level I incidents of medications not administered. The findings are: Reviews between 10/6/21 and 10/11/21 of facility incident reports between 7/1/21 - 10/6/21 revealed no level 1 incident reports for medications documented as not administered (NA). Finding #1: Review on 10/6/21 of client #1's record revealed a 15 year old female admitted 4/24/21 with diagnoses that included major depressive disorder, recurrent; anxiety; post traumatic stress disorder (PTSD); attention deficit hyperactive disorder (ADHD); schizo-affective disorder. Reviews between 10/6/21 and 10/11/21 of client #1's Medication Administration Records (MARs) for 7/1/21-9/30/21 revealed the following medications documented NA (not administered):		The Chief Nursing Officer and Director of Risk Management/ Performance Improvement will review the facility policy on Healthcare Peer Review Incident Reporting Process for revisions as necessary relative to reporting medications not administered.	11/19/21

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V 366	Continued From page 34 -Paliperidone ER (extended release) 6 mg (milligrams) on 7/1/21 and 7/2/21 at 9 pm. (Antipsychotic) -Lithium ER 450 mg on 8/1/21 at 5 pm. (Mood Stabilizer) -Depakote ER 500 mg on 8/1/21 at 5 pm. (Mood Stabilizer) -Cyclobenzaprine 5 mg on 9/28/21 and 9/29/21 at 7 pm. (Antidepressant) -Flonase 5 mcg (micrograms) nasal spray was documented as "NA" for 66 doses between 7/1/21 and 9/30/21. (Allergy Symptoms) -Lactase 3,000 units was documented as "NA" for 74 doses between 7/1/21 and 9/30/21. (Lactose Intolerance) Finding #2: Review on 10/8/21 of client #2's record revealed a 16 year old female admitted 10/17/20 with diagnoses that included bipolar 1 disorder, and ADHD. Reviews between 10/8/21 and 10/11/21 of client #2's MARs for 7/1/21-9/30/21 revealed the following medications documented, "NA." -Aripiprazole 15 mg on 7/18/21 at 9 am. (Mental/mood disorders) -Benztropine 1 mg on 7/18/21, 7/27/21, 7/31/21 at 9 am; and, 8/1/21 at 5 pm. (Involuntary movements) -Clozapine 25 mg on 7/14/21 at 9 pm. (Antipsychotic) -Clozapine 150 mg on 7/19/21 at 9 pm. -Clozapine 300 mg on 7/125/21 at 9 pm. -Depakote ER 1250 mg on 7/14/21, 8/20/21, and 8/21/21. -Docusate 100 mg on 7/31/21 and 8/23/21 at 9 am; 8/25/21 and 8/26/21 at 5 pm; 8/1/21, 8/21/21, and 8/22/21 at 9 am and 5 pm. (Constipation) -Ethnyl at 9 am on 7/8/21, 7/27/21, 7/31/21,	V 366		

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V 366	Continued From page 35 8/1/21, 9/4/21-9/6/21, 9/8/21-9/18/21. -Eucerin Cream scheduled applications were documented "NA" for 48 of 62 doses in July 2021, 44 of 62 doses in August 2021, and 57 of 60 doses in September 2021. (Dry skin) -Guanfacine 4 mg on 7/18/21, 7/27/21, 7/31/21 at 9 am. (ADHD) -Hydroxyzine 50 mg on 7/12/21, 7/13/21, 7/21/21, and 8/1/21 at 1 pm; 7/18/21, 7/27, and 7/31/21 at 9 am; and 8/1/21 at 5 pm. (Mental/Mood disorders) -Loratadine 10 mg on 7/18/21, 7/27/21, and 7/31/21 at 9 am. (Allergy symptoms) -Oxcarbazepine 300 mg on 7/18/21, 7/27/21, and 7/31/21 at 9 am; 7/12/21, 7/13/21, 7/21/21, and 8/1/21 at 1 pm; and, 8/1/21 at 5 pm. (Mood stabilizer) -Clotrimazole topical 1% cream was documented "NA" for 26 of 28 scheduled applications between 9/1/21 and 9/14/21. (Antifungal) -Metformin 500 mg on 7/27/21, 7/31/21, and 8/1/21 at 9 am; 7/17/21 and 8/1/21 at 5 pm. (Appetite suppressant) Finding #3: Review on 10/8/21 of client #3's record revealed a 15 year old female admitted 1/12/21 with diagnoses of disruptive mood Dysregulation disorder, pre-diabetes, obesity, and bipolar disorder. Reviews between 10/8/21 and 10/11/21 of client #3's MARs for 7/1/21-9/30/21 revealed the following medications documented, "NA." -Eucerin Cream was documented "NA" for 152 scheduled applications between 7/01/21 and 9/30/21. -Duloxetine DR 60 mg on 7/03/21, 7/13/21, 7/17/21, 7/21/21, 7/23/21, 7/26/21, 8/01/21, 8/09/21, 8/14/21, 8/15/21, 9/16/21, 9/21/21, and	V 366		

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	20040012	A. BUILDING: _____ B. WING _____	10/20/2021

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V 366	Continued From page 36 9/25/21 at 9:00am. (Antidepressant) -Duloxetine DR (delayed release) 30 mg, 7/03/21, 7/13/21, 7/17/21,7/21/21, 7/23/21, 7/26/21 at 9:00am. -Metformin 500 mg on 7/03/21, 7/13/21, 7/17/21, 7/21/21, 7/23/21, 7/26/21, 8/01/21, 8/09/21, 8/14/21, 8/15/21, 9/16/21, 9/21/21, and 9/25/21 at 9:00am. -Melatonin 6 mg on 7/02/21 T 9:00pm. (Sleep aid) -Thorazine 300 mg, 8/02/21 at 9:00pm. (Antipsychotic) -Thorazine 100 mg on 7/03/21, 7/17/21, 7/21/21, 7/23/21, 7/26/21, 8/01/21, 8/09/21, 8/14/21, and 8/15/21 at 9:00am; 7/05/21 and 8/09/21 at 1:00pm. -Thorazine 50 mg on 7/05/21 and 7/12/21 at 1:00pm; and 7/09/21, 7/13/21, and 9/17/21 at 9:00am. -Cogentin (Benztropine) 1 mg on 7/03/21, 7/13/21, and 7/17/21 at 9:00am. (Tremors) -Cogentin 0.5 mg on 7/21/21, 7/23/21, and 7/26/21 at 9:00am. -Abilify (Aripiprazole) 5 mg on 9/16/21 at 9:00am. (Bipolar disorder) -Abilify 10 mg on 9/21/21 and 9/25/21 at 9:00am. -Topamax 200 mg on 9/15/21 at 9:00pm. (Bipolar disorder) Interview on 10/8/21 the Pharmacist stated NA on the MARs meant the medication was "not administered." Interview on 10/8/21 the Staff Nurse #3 stated: -When a client refused their medications she would try to "educate" them. -She would document the refusal in the electronic MAR and make a nursing note. -She would not complete an incident report or medication error report.	V 366		

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V 366	Continued From page 37 Interview on 10/8/21 the Director of Nursing stated: -NA would be used to document medication refusals. -The nurses are not required to complete an incident or medication error report for medication refusals. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified	V 367		

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V 367	Continued From page 38	V 367		

or responding.
(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:
(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information required on the incident form that was previously unavailable.
(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:
(1) hospital records including confidential information;
(2) reports by other authorities; and
(3) the provider's response to the incident.
(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).
(e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:
(1) medication errors that do not meet the

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V 367	Continued From page 39 definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report Level II incidents as required to the LME (Local Management Entity) within 72 hours. The findings are: Review on 10/18/21 of facility incident reports from 7/1/21 through 10/18/21 revealed: -9/11/21 client #4 was placed in a 2 person restraint and seclusion for aggression/assault of a peer. -9/18/21 client #4 grabbed client #5 by the hair and kicked client #5 in the cheek and eye. -9/18/21 client #5 was sent to the local emergency room for an eye injury caused by client #4's kicks to her right cheek and eye, diagnosed with a corneal abrasion and prescribed eye drops.	V 367	The Director Risk Management/ Performance Improvement will ensure any Level II incidents are reported to IRIS and DRNC within 72 hours of occurrence. All reports and verifications are filed by date and maintained by the Director of Risk Management/ Performance Improvement. The Director of Risk Management/ Performance Improvement has been provided with the IRIS reporting manual and has reviewed said manual for training on reporting criteria and requirements. 100% of all incident reports are discussed and reviewed daily by leadership in Flash meetings.	10/21/21 10/22/21 10/21/21

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V 367	Continued From page 40 -10/7/21 client #6 walked up behind a peer and grabbed her buttocks. A report was filed with the local police department. -10/7/21 client #4 had her buttock grabbed by a peer. A report was filed with the local police department. Reviews between 10/6/21 and 10/20/21 of the facility's North Carolina Incident Response Improvement System (IRIS) reports from 7/1/21 through 10/18/21 revealed no level 2 incidents had been reported for the 5 incidents listed above dated 9/11/21, 9/18/21, and 10/7/21. Interview on 10/18/21 the Director of Risk Manager stated: -The listing and descriptions given to the surveyors was the incident reports for the facility. -The internal system of leveling incident reports had not identified the 5 incidents listed above on 9/18/21 and 10/7/21 to be level 2 incidents. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 367		
V 525	27E .0104(e17) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (17) The facility shall conduct reviews and reports on any and all use of restrictive interventions, including: (A) a regular review by a designee of the governing body, and review by the Client Rights	V 525		

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V 525	Continued From page 41 Committee, in compliance with confidentiality rules as specified in 10A NCAC 28A; (B) an investigation of any unusual or possibly unwarranted patterns of utilization; and (C) documentation of the following shall be maintained on a log: (i) name of the client; (ii) name of the responsible professional; (iii) date of each intervention; (iv) time of each intervention; (v) type of intervention; (vi) duration of each intervention; (vii) reason for use of the intervention; (viii) positive and less restrictive alternatives that were used or that were considered but not used and why those alternatives were not used; (ix) debriefing and planning conducted with the client, legally responsible person, if applicable, and staff, as specified in Parts (e)(9)(F) and (G) of this Rule, to eliminate or reduce the probability of the future use of restrictive interventions; and (x) negative effects of the restrictive intervention, if any, on the physical and psychological well-being of the client. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to include all required information in the restrictive intervention log. The findings are: Review on 10/11/21 of the facility restrictive intervention logs from June 2021 - September 2021 revealed: -13 restrictive intervention episodes were documented to include 4 seclusions, 6 physical restraints, and 1 chemical restraint. -The log did not include the following required documentation: -reason for use of the intervention.	V 525	Chief Nursing Officer and Director of Risk Management/Performance Improvement have revised the Restrictive Intervention log to include all required components per State regulation. The updated log was implemented for use by staff on 11/1/21.	11/1/21

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V 525	Continued From page 42 -positive and less restrictive alternatives that were used or that were considered but not used and why those alternatives were not used. -debriefing and planning conducted with the client, legally responsible person, and staff. -The log included names of "Initiating Staff," but did not document the "responsible professional." -The log included "injury" but did not document negative effects on the psychological well-being of the client. Interview on 10/11/21 the Director of Risk Management stated: -Restrictive intervention data was reviewed and analyzed quarterly. -The information not included on the log would be available on the restrictive intervention forms completed by staff.	V 525		
V 722	27G .0302 (a) DHSR Construction Approval 10A NCAC 27G .0302 FACILITY CONSTRUCTION/ALTERATIONS/ ADDITIONS (a) When construction, use, alterations or additions are planned for a new or existing facility, work shall not begin until after consultation with the DHSR Construction Section and with the local building and fire officials having jurisdiction. Governing bodies are encouraged to consult with DHSR prior to purchasing property intended for use as a facility. This Rule is not met as evidenced by: Based on interview and observation, the facility failed to consult with the DHSR Construction Section prior to making facility alterations. The findings are: Observations during facility tour between 2 pm	V 722	The Director of Plant Operations will consult with the DHSR Construction Section prior to making any future facility construction, use, alterations, or additions. Work will not commence until after consultation with and approval by DHSR Construction Section, with Onslow County building and fire officials having jurisdiction.	10/21/21

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V 722	Continued From page 43 and 3 pm on 10/6/21 revealed: -A total of 6 client bedrooms. -A window approximately 24 inches wide and 6 inches tall had been installed in each bedroom entry door. Interviews on 10/7/21 and 10/11/21 the Director Operations Manager stated: -The clients on the unit had to be quarantined around August 2021 due to positive COVID (Coronavirus) cases. -Equipment was mounted in the ceilings to provide negative pressure in the client rooms. -The only way to maintain negative pressure was to keep the doors closed. -The windows were installed in the doors so the clients could be monitored during this time the doors had to remain closed. -No one had consulted with the DHSR Construction Section about installation of the windows.	V 722		

BRYNN MARR HOSPITAL
192 Village Drive · Jacksonville, NC 28546 · P: 910-577-1400 · F: 910-577-2760 · www.brynnmarr.org

November 18, 2021

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

RE: Annual, Complaint, and Follow up Survey Completed October 20, 2021

To Whom It May Concern:

Enclosed you will find Brynn Marr Hospital's Plan of Correction in response to the Statement of Deficiencies Form received on November 8, 2021. An emailed copy was also sent securely to Tonya Bridges, Administrative Specialist, on November 18, 2021.

Brynn Marr Hospital is committed to providing quality mental health treatment to our patients. For any questions regarding our response, please do not hestitate to contact us at (910) 577-1400.

Sincerely,

Valerie Littlefield, CEO
Brynn Marr Hospital