STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHH0976	A. BUILDING: _____ B. WING _____	09/27/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint and follow up survey was completed on September 27, 2021. The complaints were unsubstantiated (intake #NC00181080, #NC00181283, #NC00180746, #NC00180910, #NC00180900, #NC00180881, #NC00180790, #NC00181195, #NC00180857). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment Facility for Children and Adolescents.	V 000	Carolina Dunes Behavioral Health takes these findings seriously and has implemented what we feel is an effective plan of action to address the identified deficiencies and monitor for compliance with actions taken. Pursuant to your request, the response is structured as follows: 1) the measures put in place to correct the deficient practice, 2) the measures put in place to prevent the problem from occurring again, 3) the person who will monitor the situation to ensure it will not occur again, and 4) how often the monitoring will take place.	
V 315	27G .1902 Psych. Res. Tx. Facility - Staff 10A NCAC 27G .1902 STAFF (a) Each facility shall be under the direction a physician board-eligible or certified in child psychiatry or a general psychiatrist with experience in the treatment of children and adolescents with mental illness. (b) At all times, at least two direct care staff members shall be present with every six children or adolescents in each residential unit. (c) If the PRTF is hospital based, staff shall be specifically assigned to this facility, with responsibilities separate from those performed on an acute medical unit or other residential units. (d) A psychiatrist shall provide weekly consultation to review medications with each child or adolescent admitted to the facility. (e) The PRTF shall provide 24 hour on-site coverage by a registered nurse.	V 315	V 315 In order to ensure that a 2:6 direct care staff to patient ratio is maintained at all times, the Director of Nursing and Program Manager will report daily to the CEO in the Safety meeting the number of staff scheduled for that day and the following day. To help stabilize facility staffing, the administration has approved a significant increase to the starting salary for the MHT position. A Program Director position has been created to centralize responsibility for unit staffing. The census will be capped as needed on the PRTF units when appropriate staffing cannot be guaranteed due to staffing shortages.	9/24/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHH0976	A. BUILDING: _____ B. WING _____	09/27/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 315	Continued From page 1 This Rule is not met as evidenced by: Based on record review 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 9/23/21 of the "Facility Daily Staffing Sheet" dated 9/23/21 for 1st shift revealed: -3 staff worked on 100 Hall. -3 staff worked on 400 Hall. Review on 9/23/21 of the client census of the facility dated 9/23/21 revealed: -There were 11 residents on 100 hall. -There were 12 residents on 400 hall. Interview on 9/24/21 client #4 stated: -There were typically 2 to 3 staff per shift. -There were rarely 4 staff per shift. -There were 12 residents. Interview on 9/24/21 client #5 stated: -There were 2 to 3 staff per shift. -There were as few as 9 residents and as many as 12 to 13 residents. Interview on 9/24/21 client #6 stated: -There were 2 to 4 staff per shift. -Most of the time there were 2 staff per shift. -There were 12 residents on his hall. Interview on 9/24/21 client #8 stated: -There were 1 to 4 staff per shift. -Morning shift typically had 2 to 3 staff. -Afternoon 2nd shift typically had 2 to 4 staff. -There were 12 residents on the hall. Interview on 9/27/21 staff #2 stated: -He worked 2nd shift 3pm-11pm. -There were 2 to 4 staff per shift.	V 315	The Lead MHTs have been empowered to offer critical shift incentive pay to help cover vacant MHT shifts. A central call-out phone is being provided which is answered by a Lead MHT to ensure that coverage for the vacant shift is obtained in a timely manner. In the event of an unforeseen staff vacancy, the Milieu Manager will notify the designated MHT(s) that they must stay until appropriate relief can be obtained. The Lead MHTs are responsible for obtaining this relief coverage The facility is using OnShift scheduling software to communicate with employees through blast messages regarding vacant shifts. The Program Manager will monitor staffing ratio compliance and report to the CEO twice daily with an update the following day. The Program Manager is responsible for maintaining the appropriate 2:6 direct care staff to patient ratio. The Program Manager will monitor this process daily and report any discrepancies and corrective action to the CEO in the Safety meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHH0976	A. BUILDING: _____ B. WING _____	09/27/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 315	Continued From page 2 Interview on 9/27/21 Director of Quality & Risk Management stated: -Client admissions had been reduced and capped, in an effort to remain compliant with required staffing ratios.	V 315		
V 522	27E .0104(e10) 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: (10) The emergency use of restrictive interventions shall be limited, as follows: (A) a facility employee approved to administer emergency interventions may employ such procedures for up to 15 minutes without further authorization; (B) the continued use of such interventions shall be authorized only by the responsible professional or another qualified professional who is approved to use and to authorize the use of the restrictive intervention based on experience and training; (C) the responsible professional shall meet with and conduct an assessment that includes the physical and psychological well-being of the client and write a continuation authorization as soon as possible after the time of initial employment of the intervention. If the responsible professional or a qualified professional is not immediately available to conduct an assessment of the client, but concurs that the intervention is justified after discussion with the facility employee, continuation of the intervention may be verbally authorized	V 522	V 522 In order to ensure that each client with a restrictive intervention of more than 15 minutes has verbal and written authorization, as well as a physical and mental well-being assessment by a qualified professional that extended the restrictive intervention, The Director of Nursing will conduct re-training on this expectation with all Registered Nurses. This training will begin with Nursing Department meetings on March 30, 2022 and any Registered Nurse who is unable to attend the meeting will receive the training prior to their next shift worked. The RN who failed to document 15-minute observations on the one patient in question was an agency nurse whose contract ended prior to the survey and was not reviewed due to problems with documentation. The Director of Quality, Compliance, and Risk Management will add Restraint/ Seclusion 15-minute Flowsheet compliance as a standing agenda item to the daily Safety Committee agenda. Any restrictive interventions over 15 minutes without appropriate documentation will be	4/18/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHH0976	A. BUILDING: _____ B. WING _____	09/27/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 522	Continued From page 3 until an on-site assessment of the client can be made; (D) a verbal authorization shall not exceed three hours after the time of initial employment of the intervention; and (E) each written order for seclusion, physical restraint or isolation time-out is limited to four hours for adult clients; two hours for children and adolescent clients ages nine to 17; or one hour for clients under the age of nine. The original order shall only be renewed in accordance with these limits or up to a total of 24 hours. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure each client with a restrictive intervention (RI) of more than 15 minutes had verbal and written authorization, as well as, a physical and mental well-being assessment by a qualified professional that extended the RI for 1 of 7 current audited clients (#6). The findings are: Review on 9/23/21-9/24/21 of client #6's record revealed: -13 year old male. -Admitted on 5/7/21. -Diagnoses of Bipolar Disorder, unspecified, Disruptive Mood Dysregulation Disorder and Oppositional Defiant Disorder. Review on 9/23/21 of the Facility's policy and procedure manual for seclusion and Physical or Chemical Restraint dated October 2015 revealed: -"After all reasonable attempts at lesser alternatives (least restrictive approach) to seclusion or restraint have been attempted, the Registered Nurse will consult with the psychiatrist who is provided to clear assessment of the	V 522	referred to the Director of Nursing for re-training and appropriate corrective action. The Director of Quality, Compliance, and Risk Management will monitor all restrictive interventions for compliance as a standing agenda item in the daily Safety Committee. Monitoring will be conducted every weekday in the daily Safety Committee meeting and reported monthly to the Quality Council.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHH0976	A. BUILDING: _____ B. WING _____	09/27/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 522	Continued From page 4 patient's current status and the client's physical and psychological condition. Only Registered Nurses can obtain orders for restraint or seclusion...Seclusion used for the management of violent or self destructive behaviors that jeopardizes the immediate physical safety or the patient, a staff member, or others may only be renewed in accordance with the time and age limits within a 24 hour period...Children/Adolescents age 9 and above: Up to two hours...In the event the physical restraint or seclusion is extended, a new written or phone order must be obtained...continuous observations are documented at least every 15 minutes...Documentation includes any interventions provided and patients response to interventions...Seclusion will be documented by a registered nurse in the patient's medical record and will reflect justification, lesser restrictive measures attempted and failed to prior to restraint/seclusion, implementation, and outcome of procedure..." Review on 9/23/21 of the facility's MD Order Form Physical Restraint/Seclusion for client #6 dated 8/23/21 revealed: -Intervention initiated at 9:06. -"Reason for RI: Imminent risk of harm to others" -"Seclusion...Start date: 8/23/21 Start time: 0906 End date:8/23/21 End time: 1106" -There was no indication of a renewal order to continue seclusion. Review on 9/23/21 of the facility's restraint/seclusion monitoring sheet for client #6 dated 8/23/21 revealed: -"RN: Assess patient at initiation and every 15 minutes thereafter...Document monitoring of patient at least every 15 minutes." -"Time 0906...Mental Status 4(Threatening),	V 522		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHH0976	A. BUILDING: _____ B. WING _____	09/27/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 522	Continued From page 5 5(Agitated)...Behavior 5 (Can't follow directions), 4 (Crying)..." -"Time 1100...Mental Status 1(Oriented)...Behavior (Cooperative)..." -There was no additional monitoring times listed different from those listed above. -There was no indication monitoring occurred at least every 15 minutes. Interview on 9/24/21 client #6 stated: -Staff kept "putting me in the quiet room and giving me needle injections." -Staff did not call his grandmother when he was placed in a RI or seclusion. -Staff kept him in "the quiet room for an hour until around lunch time at 1pm." Interview on 9/24/21 the Director of Nursing stated: -Seclusion was used as a last resort. -A client who was too aggressive and unsafe to be held in a restraint safely may be placed in seclusion. -History and background were considered when a client was placed in seclusion. -Seclusions required a physician order, new order after 60 minutes, a Mental Health Technician at the seclusion door at all times and nurse checks every 15 minutes. -A flow sheet was used to document 15 minutes checks by the nurse. -Seclusions could not exceed 2 hours for children. -Former registered nurse (FRN) #1 requested seclusion for client #6 on 8/23/21. -There was no evidence FRN #1 completed 15 minute checks or requested a renewal order for seclusion. -FRN #1's contract ended on 9/14/21 and the facility chose not to renew the contract.	V 522		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHH0976	A. BUILDING: _____ B. WING _____	09/27/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 522	Continued From page 6 -She reviewed charts from FRN #1 that had consistent use of seclusions. -She contacted the contracted agency of FRN #1 to report her chart findings and report FRN #1's performance.	V 522		
V 742	27G .0304(a) Privacy 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (a) Privacy: Facilities shall be designed and constructed in a manner that will provide clients privacy while bathing, dressing or using toilet facilities. This Rule is not met as evidenced by: Based on record reviews, observation and interviews, the facility failed to ensure facilities were designed in a manner that provided privacy while dressing for 2 of 7 current audited clients (#1, #2). The findings are: Finding #1 Review on 9/27/21 of client #1's record revealed: -15 year old female. -Admission date of 7/10/21. -Diagnosis of Major Depressive Disorder, recurrent severe without psychotic symptoms. Interview on 9/27/21 client #1 stated: -She resided at the facility for approximately 2 months. -She resided in room 104 for approximately 2 weeks. -She was without a door for the two weeks she had been in room 104. -She did not have a shower curtain and bathroom curtain for privacy for 2 weeks.	V 742	V 742 The two bedroom doors that were missing at the time of the survey were on order and have subsequently been replaced. The shower curtains that were missing at the time of the survey were replaced during the survey. In order to ensure that each client has privacy while bathing, dressing, or using toilet facilities, the Environment of Care Director is conducting a weekly "Pristine Survey" of all patient care areas. Broken or missing doors and missing shower curtains are noted on the survey and ordered as needed. Extra shower curtains are being kept on hand so no patient should have to wait on an order to have a shower curtain replaced. In the event of a broken bedroom door, the bedroom will be closed to occupancy and the patient placed in another room until the door can be replaced. The Environment of Care Director is conducting a weekly "Pristine Survey" of all patient care areas. Broken or missing doors and missing shower curtains are noted on the survey and ordered as needed. Extra shower curtains are being	3/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHH0976	A. BUILDING: _____ B. WING _____	09/27/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 742	Continued From page 7 -She dressed herself in the bathroom. Finding #2 Review on 9/24/21 of client #2's record revealed: -13 year old female. -Admission date of 6/15/21. -Diagnosis of Major Depressive Disorder, recurrent, unspecific. Interview on 9/24/21 client #2 stated: -She resided at the facility for 3 months. -She resided in room 107. -She was without a room door for a couple of days. -She did not have a shower curtain and bathroom curtain for privacy for 2 months. -She dressed herself in the bathroom. Finding #3 Review on 9/23/21 of a facility's work order #20909 dated 7/8/21 revealed: -"Summary *Door is gone." -"Area * Resident Room - 104." Observation on 9/23/21 of the facility's client residential halls between 11:45am and 1pm revealed: -Room 104 and 107 were missing room doors, bathroom doors/curtains and shower curtains. -Room 206, 301, and 307 were missing bathroom doors/curtains and shower curtains. Interview between 9/23/21-9/27/21 the Environment of Care Director stated: -Room 104 and 107 did not have room doors. -Room 104's door was removed before she was employed at facility. -She was unsure when room 107's door was removed. -The doors were ordered and the facility received	V 742	kept on hand so no patient should have to wait on an order to have a shower curtain replaced. In the event of a broken bedroom door, the bedroom will be closed to occupancy and the patient placed in another room until the door can be replaced. The Environment of Care Director will report weekly in the Safety Committee meeting on the results of the weekly Pristine Survey and any corrective actions taken or needed. Monitoring will be conducted weekly with the Pristine Survey and reported weekly in the daily Safety Committee meeting and monthly to the Quality Council.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHH0976	A. BUILDING: _____ B. WING _____	09/27/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 742	Continued From page 8 the doors the prior week. -The doors were in the process of being stained and would be installed in 3 to 4 days. -She would ensure bathroom door/curtains and shower curtains were replaced on 9/23/21. -The resident room doors for 104 and 107 had been replaced on 9/24/21.	V 742		