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 _____	04/08/2022

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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 An annual, complaint and follow-up survey was completed on April 8, 2022. Eight complaints were substantiated (intake #NC00183086, #NC00183192, #NCNC00183767, #NC00185509, #NC00186031, #NC00186333, #NC00186878, #NC00187485) and five complaints were unsubstantiated (#NC00183397, #NC00184587, #NC00184671, #NC00183753, #NC00187984). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment Facility for Children and Adolescents. This facility is licensed for 72 and currently has a census of 60. The survey sample consisted of audits of 12 current clients and 4 former clients.	V 000		
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.	V 114		

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V 114	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interviews the facility failed to have disaster drills held at least quarterly and repeated on each shift. The findings are: Review on 3/30/22 and 4/1/22 of facility records from 4/1/21 - 3/31/22 revealed: - 2nd quarter (7/01/21 - 9/30/21): There was a 96-hour table top disaster drill documented on 9/28/21 but no disaster drills simulating a disaster for 1st, 2nd, or 3rd shifts. - 3rd quarter (10/01/21- 12/31/21): There were no disaster drills documented on the 1st and 2nd shifts. - 4th quarter (1/01/22 - 3/30/22): There was a 96-hour table top disaster drill documented from 3/22/22 - 3/25/22 but no disaster drills simulating a disaster for 1st, 2nd, or 3rd shifts. Interview on 4/6/22 client #5 stated: - She had been with the facility for approximately 2 months. - She had not completed a disaster drill while at the facility. Interview on 4/6/22 client #6 stated: - She had been with the facility for approximately 8 months. - She had not completed a disaster drill while at the facility. Interview on 4/8/22 staff #1 stated: - He had been employed with the facility for approximately 1 year and 3 months - He had not completed a disaster drill while at the facility. Interview on 4/8/22 staff #7 stated: - She had been employed with the facility for	V 114		

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V 114	Continued From page 2 approximately 5 years. - She had not completed a disaster drill in approximately 1 year. Interview on 4/6/22 the Director of Plant Operations stated: - She had completed 96-hour table top disaster reviews in September, 2021 and March, 2022 reviewing disaster preparation with administrative staff.	V 114		
V 115	27G .0208 Client Services 10A NCAC 27G .0208 CLIENT SERVICES (a) Facilities that provide activities for clients shall assure that: (1) space and supervision is provided to ensure the safety and welfare of the clients; (2) activities are suitable for the ages, interests, and treatment/habilitation needs of the clients served; and (3) clients participate in planning or determining activities. (h) Facilities or programs designated or described in these Rules as "24-hour" shall make services available 24 hours a day, every day in the year. unless otherwise specified in the rule. (c) Facilities that serve or prepare meals for clients shall ensure that the meals are nutritious. (d) When clients who have a physical handicap are transported, the vehicle shall be equipped with secure adaptive equipment. (e) When two or more preschool children who require special assistance with boarding or riding in a vehicle are transported in the same vehicle, there shall be one adult, other than the driver, to assist in supervision of the children.	V 115		

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V 115	Continued From page 3	V 115		

This Rule is not met as evidenced by:
Based on record reviews and interviews the facility failed to provide supervision to ensure safety and welfare of one of 12 audited current clients (#9). The findings are:

Review on 4/7/22 of client #9's record revealed:
-17 year-old female
-Admission date of 1/26/22
-Diagnoses of personality disorder- unspecified, conduct disorder- adolescent onset

Review on 4/8/22 of an Investigation Report dated 4/8/22 revealed:
-Client #9 completed 6 separate calls to former staff (FS) #10 's personal cell phone.
-Video surveillance confirmed client #9 on the phone at the time of calls placed to FS #10 on 3 separate dates.
-The internal investigation confirmed FS #10 had provided his personal cell number and was having ongoing communication with client #9 through the unit phone.

Interview on 4/7/22 client #9 stated:
-The protocol for making phone calls required staff obtaining a portable phone, reviewing the approved telephone numbers, and dialing the number. The staff then verified the individual receiving the call by requesting a pass code before providing the client with the phone.
-Clients were allowed to be on the phone for 15 minutes and were able to walk away from staff for more privacy.

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V 115	Continued From page 4 -Due to the ability to separate from staff, a client could hang-up the phone and dial a number not on the approved list after walking away. Interview on 4/8/22 client #10 stated: -She had ben at facility for 2.5 months. -She had witnessed client #9 call FS #10 on facility phone for approximately 10 minutes. There were 3 staff working at the time of the call, with one staff in the bin room, one staff on break, and the third staff in the day room. -The protocol for making phone calls required staff to dial the number and then request the call recipient to provide a code. The call was then documented in a log. -She had witnessed an incident where staff had left the phone unattended and a client made an unauthorized call. -Staff recorded the calls on the call log approximately 35% of the time. Interview on 4/8/22 staff #1 stated: -He had been employed with the facility for 1 year and 3 months. -Clients can receive phone calls for up to 15 minutes. -Staff were required to dial the number and approve the called through password verification. -Staff were to be present while client used the phone, but due to staff shortages sometimes the client could be on the phone unmonitored. -Staff were to log entries of all phone calls following the call. The entry would have the staff's name, time, duration of the call, who was called, reason for the call, and how the call went. -He had gone back through and found discrepancies on multiple occasions where staff had not documented the calls made in the logbook. -He had not been informed of any phone call	V 115		

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V 115	Continued From page 5 policy changes. Interview on 4/7/22 staff #8 stated: -She had been employed with the facility for approximately 2 years. -The phone used for client calls was maintained in a locked "bin room." -She was aware of an incident last year when the bin room was left unlocked and a client was able to gain unapproved access to the bin area. -She believed calls were accurately logged in the log book about "85% of the time." Interview on 4/7/22 the Program Manager stated: -The policy for clients making phone calls included staff reviewing approved client phone list, dialing the number, verifying the appropriate recipient by requesting a passcode, and then recording the call in a log. -While there was generally a staff who handled phone calls, there were no staff specifically assigned to monitoring phone calls. -Following a recent misuse of client phone calls, management were working to ensure staff verified the last number dialed, identified a specific place to monitor phone calls, completed a weekly audit of phone logs, and created a shift assignment to create accountability. -The new protocol had been discussed and approved earlier that morning but had not yet been implemented.	V 115		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written	V 118		

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V 118	Continued From page 6 order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record review, observation, and interview, the facility failed to ensure medications were administered as ordered and MARs were accurate affecting 3 of 12 current clients audited (clients #3, #7, #8). The findings are: Finding #1:	V 118		

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V 118	Continued From page 7 Review on 4/5/22 of client #8's record revealed: -15 year old female admitted 1/17/22 with diagnoses to include Major Depressive Disorder (MDD), recurrent, severe without psychotic features; Post Traumatic Stress Disorder (PTSD); and Attention Deficit Hyperactive Disorder (ADHD). -4/3/22 client was evaluated at the local hospital emergency department (ED) for a wrist injury and diagnosed with a sprain of the right wrist. -4/3/22 prescription written by the ED physician for diclofenac-sodium (Voltaren) topical gel, four times a day for 7 days. -3/28/22: Remeron 15 mg (milligrams) at bedtime. (mood) -1/17/22: Trazadone 150 mg at bedtime (depression; sleep) -1/18/22: Fluoxetine 20 mg (depression) -1/17/22: Prazosin 5 mg at bedtime (nightmares) Review on 4/6/22 of client #8's MARs (1/1/22 - 4/6/22) revealed: -No Voltaren topical gel transcribed or administered as ordered 4/3/22. -3/28/22: Remeron 15 mg at bedtime. (mood) was not documented on 3/29/22. -2/22/22, 2/23/22: Trazadone 150 mg was documented twice at 8 pm on 2/22/22 and not documented on 2/23/22. -1/23/22, 1/24/22: Fluoxetine 20 mg documented twice at 8 pm on 1/23/22 and not documented on 1/24/22. -1/20/22, 1/21/22: Prazosin 5 mg documented twice at 8 pm on 1/20/22 and not documented on 1/21/22. Interview on 4/6/22 client #8 stated: -Client was seen "a few days ago" in the ED and received medications. -Client was supposed to get a topical medication,	V 118		

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V 118	Continued From page 8 but she had not received it and it was not in the building. -Her shoulder was hurting more than her hand. -Her fingers felt numb and tingly. -She had her shoulder x-rayed 4/6/22. Observation on 4/6/22 between 12:30 pm and 6:30 pm revealed: -Client client #8 was wearing a splint on her right arm below her elbow. -There was no Voltaren topical gel medication on hand. Finding #2: Review on 4/5/22 of client #7's record revealed: -15 year old female admitted 12/2/21 with diagnoses to include Dysruptive Mood Dysregulation Disorder (DMDD), PTSD, and ADHD. -Orders dated 12/3/21: -Dexmethylphenidate ER (extended release) 40 mg (ADHD) -Lactobacillus rhamnosus 1 capsule (digestion) -Levothyroxine 75 mcg (micrograms) at 7am (hypothyroidism) -Omega 3 - 1,000 mg twice daily (high lipids) -Clonidine 0.1mg twice daily (ADHD) Review on 4/6/22 of client #7's MARs (January - March 2022) revealed: -1/4/22: Levothyroxine 75 mcg at 0700 was not administered; nurse documented the medication could not be found in the automated medication dispensing system. -1/23/22: Dexmethylphenidate ER 40 mg was not administered; documented the medication was not available. -3/14/22: Omega-3 was not administered; documented the medication was not available.	V 118		

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V 118	Continued From page 9 -3/7/22: Clonidine 0.1 mg was documented as given 3 times on 3/7/22 (8 am, 8 pm, 8 am) and once on 3/8/22 (8 pm). -3/29/22: Lactobacillus rhamnosus 1 capsule not documented at 8 pm. Finding #3: Review on 4/1/22 of client #3's record revealed: -16 year old male admitted 3/8/22 with diagnoses to include MDD, DMDD; ADHD, combined type; PTSD. -No order to continue Vyvanse 70 mg (ADHD) after admission. Review on 4/6/22 of incident report dated 3/11/22 revealed LPN #1 had administered Vyvanse 70 mg on 3/11/22 at 9:40 am because the medication was in the medication cart and she failed to note it was not on the client's MAR. Interviews from 4/1/22 -4/6/22 the Director of Nursing (DON) stated: -If a medication error was identified a variance report was completed and sent to the DON and she would follow up. -If the pharmacy identified an error they would complete a variance report and send to the DON. -The electronic medication system will populate the MAR with the physician orders. -On admission the nurse will administer medications from the client's home medications until the orders were filled by the pharmacy. -The pharmacy hours on site are Monday - Friday from 8 am - 5 pm. Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician.	V 118		

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V 120	Continued From page 10	V 120		
V 120	27G .0209 (E) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) separately for external and internal use; (E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure (1) client medications were stored separately for each client; and (2) internal medications were stored separately from external medications affecting 1 of 12 current clients audited (client #7). The findings are: Observations on 4/6/22 between 5:50 pm and 6:30 pm of medication cart storage revealed: -200 Hall: The top drawer of the medication cart	V 120		

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V 120	Continued From page 11 on the 200 hall was used to store 31 medications for various clients with examples as follows: -Client #7: Flonase nasal spray (seasonal allergies) -Client #12: Flovent HFA (hydrofluoroalkane) 44 mcg (micrograms) (asthma); Proair HFA 90 mcg inhaler (asthma) -Client #13: Ambesol (topical anesthetic) -Client #14: Generic "Wart Remover" topical, over the counter medication -400 Hall: 7 Proair HFA 90 mcg inhalers were stored in the top drawer of the medication cart labeled with the names of 5 different clients (clients #15, #16, #17, #18, #19). Interview on 4/6/22 the Director of Nursing stated: -Any client medication that is not dispensed in a bubble pack is stored in the top drawer of the medication cart on that client's hall. -This is not a new practice and had not been identified as out of compliance to her knowledge. -She would work with the staff to find solutions to medication storage keeping client medications separate and internal medications separate from external medications.	V 120		
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	V 314		

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V 314	Continued From page 12 on a 24-hour basis. (d) Therapeutic interventions shall address functional deficits associated with the child or adolescent's diagnosis and include psychiatric treatment and specialized substance abuse and mental health therapeutic care. These therapeutic interventions and services shall be designed to address the treatment needs necessary to facilitate a move to a less intensive community setting. (e) The PRTF shall serve children or adolescents for whom removal from home or a community-based residential setting is essential to facilitate treatment. (f) The PRTF shall coordinate with other individuals and agencies within the child or adolescent's catchment area. (g) The PRTF shall be accredited through one of the following; Joint Commission on Accreditation of Healthcare Organizations; the Commission on Accreditation of Rehabilitation Facilities; the Council on. Accreditation or other national accrediting bodies as set forth in the Division of Medical Assistance Clinical Policy Number 8D-1, Psychiatric Residential Treatment Facility, including subsequent amendments and editions. A copy of Clinical Policy Number 8D-1 is available at no cost from the Division of Medical Assistance website at http://www.dhhs.state.nc.us/dma/. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to coordinate client care with other individuals and agencies affecting 1 of 12	V 314		

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V 314	Continued From page 13 audited current clients (client #1). The findings are: Review on 3/30/22 of client #1's record revealed: -17 year old male admitted 12/21/22 from a state psychiatric hospital. -Diagnoses included Post Traumatic Stress Disorder (PTSD); Attention Deficit Hyperactive Disorder (ADHD), Bipolar, Vitamin D deficiency, and Ventricular Septal Defect (VSD). -The discharge summary from the state psychiatric hospital documented an appointment had been scheduled for 3/3/22 with client #1's pediatric cardiologist for his annual follow up for VSD. The physician's name and practice address was documented in the discharge summary. -There was no documentation client #1 had been seen on 3/3/22 by his pediatric cardiologist or any other physician for his annual VSD follow up . Interview on 4/6/22 the Director of Nursing (DON) stated: -There was a staff assigned to make appointments for clients and record them in the unit scheduling book. -The DON had looked and did not see any documentation of the appointment for client #1 with his cardiologist in the scheduling book. -Typically, the staff would get an order from the facility physician to schedule needed appointments with other physicians. -Client #1 had an electrocardiogram (EKG) done 2/28/22, but there was no documentation of a cardiology appointment. -Given this appointment was documented in the admission paperwork and discharge summary from the psychiatric hospital, she thought it possible the staff scheduler had not been made aware of the appointment and it had been	V 314		

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V 314	Continued From page 14 missed. -Now that she was aware, an appointment had been scheduled for 5/12/22 for client #1 for his annual VSD follow up.	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. (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 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 4/8/22 of the "Facility Daily Staffing Sheet" and census dated 3/29/22 revealed:	V 315		

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V 315	Continued From page 15 -100 Hall census = 16 clients -200 Hall census = 17 clients -300 Hall census =15 clients -400 Hall census = 12 clients -1st shift: 4 staff were listed as working on the 100, 200, and 300 Halls. This included a licensed nurse posted for each unit and only for the unit posted. -2nd shift: 4 staff were listed as working on the 100, 200, and 300 Halls; 3 staff were listed as working the 400 Hall. Two licensed nurses were posted to cover 2 units each. -3rd shift: 2 staff were listed as working on the 100 Hall; 3 staff were listed as working the 200, 300, and 400 Halls. Two licensed nurses were posted to cover 2 units each. Interview on 4/6/22 client #4 stated: -She had been at the facility for approximately 1.5 months. -Generally there were 3 staff working per 16 clients, but sometimes there were only 2 staff working with 16 clients on the second shift. Interview on 4/6/22 client #6 stated: -She had been at the facility for approximately 8 months. -There were usually 3 staff working each hall, but sometimes there were only 1-2 staff working the hall. Interview on 4/6/22 client #5 stated: -She had been at the facility for approximately 2 months. -There were supposed to be 3 staff working each hall, but sometimes there were only 1-2 staff working with the clients. Interview on 4/7/22 client # 9 stated: -Recently there should have been 3 staff on the	V 315		

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hall, but there was only 2.
-This was the staffing for day and evening shifts.
-Typically there were 4 nurses on day shift, but recently there had been 2 nurses on duty for all 4 halls.

Interview on 4/8/22 client #10 stated:
-She had been at the facility for about 2 ½ months.
-Normally they had 3 staff on her unit, but some days only 2 staff would be working.
-On 4/8/22 they they only had 2 staff; therefore, they could not go to school and school was done on the hall.
-She would say 45% of the time they did not have enough staff.

Interview on 4/8/22 client #11 stated:
-She had been at the facility for 7 months.
-She was currently on the "300 hall."
-There were 16 girls on her hall.
-Most of the time 1st shift will have 2 staff.
-When staff is low other staff would come to help out.
-They had to do school on the unit on 4/8/22 because they were short staffed.

Interview on 4/8/22 Staff #7 stated:
-She had worked at the facility about 5 years.
-She and 1 other staff was working the 200 hall on 4/8/22 with a census of 16 clients. One client had left on a home pass.
-When short staff the Program Manager would make more frequent rounds and the nurses would help out when they could. The Milieu Manager would help the staff when a unit was short staffed.
-The facility had recently experienced a high turnover rate that had resulted in short staffing.
-The female hall typically had 16-17 clients, and

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V 315	Continued From page 17 the male hall, 12-13 clients. -They should have 3 staff, however, they sometimes only had 2 staff working. Interview on 4/8/22 Staff#1 stated - He was a Mental Health Technician and had been employed by the facility 1 year and 3 months. -When he worked he would be in charge of the unit. -On 4/8/22 he and 1 other staff were working the "400 Hall" with 12 clients. -They were "out of ratio" due to "call outs." -Paydays and weekends were the hardest shifts to cover. Interview on 4/7/22 the Program Manager stated: -There had been some staffing "challenges." -The facility had instituted "critical pay" for a staff that agreed to work a shift that was critically short staffed. -Even with critical pay it was difficult to get staff to work shifts on a Friday or Saturday. -He had worked extra shifts to cover; nurses also flexed to increase coverage. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 315		
V 521	27E .0104(e9) 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: (9) Whenever a restrictive intervention is utilized,	V 521		

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V 521	Continued From page 18 documentation shall be made in the client record to include, at a minimum: (A) notation of the client's physical and psychological well-being; (B) notation of the frequency, intensity and duration of the behavior which led to the intervention, and any precipitating circumstance contributing to the onset of the behavior; (C) the rationale for the use of the intervention, the positive or less restrictive interventions considered and used and the inadequacy of less restrictive intervention techniques that were used; (D) a description of the intervention and the date, time and duration of its use; (E) a description of accompanying positive methods of intervention; (F) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the emergency use of seclusion, physical restraint or isolation time-out to eliminate or reduce the probability of the future use of restrictive interventions; (G) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the planned use of seclusion, physical restraint or isolation time-out, if determined to be clinically necessary; and (H) signature and title of the facility employee who initiated, and of the employee who further authorized, the use of the intervention. This Rule is not met as evidenced by: Based on record review and interview the facility failed to conduct/document post restrictive intervention client debriefs to include all persons required affecting 2 of 12 current clients audited (clients #1, #7). The findings are:	V 521		

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V 521	Continued From page 19 Finding #1: Reviews between 3/30/22 and 4/6/22 of client #1's record revealed: -17 year old male admitted 12/21/22. -Diagnoses included Post-traumatic Stress Disorder (PTSD); Attention Deficit Hyperactive Disorder (ADHD), Bipolar, Vitamin D deficiency, and Ventricular Septal Defect (VSD). -1/3/22 - Restrictive intervention for aggressive behavior at 4:10 pm that involved RN#1, Staff #1, and Staff #2. Client debriefing was documented at 4:10pm and included only the client and RN #1. -1/18/22 - Restrictive intervention for aggressive behavior at 8:49 am that involved RN#2, Staff#3, Program Manager, and RN#4. Client debriefing was documented at 9:20 am and included only the client and RN#2. -2/14/22 - Restrictive intervention for aggressive behavior at 4:40 pm that involved RN#1, Staff#1, and Staff#5. Client debriefing was documented at 4:30pm and included only the client and RN#1. -2/27/22: - Restrictive intervention for aggressive behavior at 2:37 pm that involved LPN#1; Staff #7, RN#3, RN#5, Staff#3,Staff#2, and Staff#6. Client debriefing was documented at 3 pm and included only the client and LPN#1. Finding #2: Reviews between 3/31/22 and 4/6/22 of client #7's record revealed: -15 year old female admitted 12/2/21. -Diagnoses included Dysruptive Mood Dysregulation Disorder and PTSD. -1/31/22 - Restrictive intervention for aggressive behavior at 9:00 am that involved RN#4, Staff#3, and Staff#7. Client debriefing was documented at 8:50 am and included only the client and RN#4. Interview on 4/6/22 the Director of Nursing stated: -The Nurses were documenting the client debrief	V 521		

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V 521	Continued From page 20 as it was done. -Typically after a restrictive intervention, the nurse would talk with the client and discuss what could be done differently to prevent future restrictive interventions. -The staff debrief will follow and it would include a discussion between the nurse and the staff involved in the debrief. -Typically the staff, other than the nurse, is not a part of the client debrief.	V 521		