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 ______	06/14/2022

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

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V 000	INITIAL COMMENTS A complaint survey was completed on June 14, 2022. The complaint was substantiated (intake #NC00189685). A deficiency was 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 58. The survey sample consisted of an audit of 1 current client.	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 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and	V 110	V 110 The staff member identified as failing to demonstrate the knowledge, skills, and abilities required by the population served had already been terminated from employment with Carolina Dunes Behavioral Health at the time of the survey visit. To ensure that all Mental Health Technicians understand the importance of proactive and vigilant supervision of patients, all MHTs were provided a refresher training based upon a recently developed Safety & Supervision presentation. All MHTs were required to sign an attestation of understanding regarding important supervision issues such as conducting routine observations, monitoring of patients, supervision during sleeping hours, intervening with escalating patients, preventing bullying, etc. This was initiated immediately following the survey on 6/15/2022 and was completed by all active employees by 6/21/2022. The	7-15-2022

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V 110	Continued From page 1 (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record reviews and interviews, one of four audited paraprofessional staff (staff #1) failed to demonstrate the knowledge skills and abilities required by the population served. The findings are: Review on 6/14/22 of client #1's record revealed: -14 year old female -Admission date of 2/2/22 -Diagnoses of Major Depressive Disorder Review on 6/14/22 of facility Incident Report for client #1 dated 5/16/22 revealed: -Client #1 had been in an altercation with several peers on the 300 hall at approximately 4pm. -Several peers were viewed pulling at client #1 ' s legs and pushing her as she attempted to enter a dayroom. -Staff #3 intervened and brought client #1 to safety room. -Client #1 complained of arm pain and was escorted for evaluation by nurse, -Client #1 was provided ice and ibuprofen for arm pain. -Evaluation of client #1 ' s arm revealed a bruise and slight swelling,	V 110	remaining 7 inactive employees will receive the training and sign the attestation of understanding prior to their next assigned shift. To prevent reoccurrence of this problem, all new Mental Health Technicians will receive the Safety & Supervision training and sign the attestation of understanding as part of their New Employee Orientation. The Program Manager will also provide periodic refreshers of this material within the context of the quarterly MHT supervision. The Program Manager will monitor the completion of the ongoing Safety & Supervision training by new MHTs. The Program Manager will also monitor MHT competency as evidenced by performance on an ongoing basis to ensure that any MHTs identified as in need of re-training receives it prior to working with patients again. The Program Manager will monitor the completion of the Safety & Supervision training and attestation of understanding by new MHTs monthly and provide a report monthly to the Quality Council until three consecutive months of 100% compliance are achieved.	

Division of Health Service Regulation

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V 110	Continued From page 2 Observation at approximately 4pm on 6/14/22 of facility security video dated 5/16/22 revealed: -Client #1 was observed sitting in the floor of the 300 hall outside the closed dayroom. -Client #1 attempted to make entry into the dayroom from the seated position, as the dayroom door opened. -Client stuck her arm into the open door and attempted to scoot in, but she was denied access by the clients on the inside of the room. -Two clients came out and attempted to pull client #1 out of the doorway of the dayroom by her feet. -Unknown clients were heard yelling that client #1 was attempting to get into the dayroom. -As the two clients came out of the day room and attempted to grab client #1 ' s feet, Staff #1 (located outside the day room) turned and walked back up the hallway to notify staff #2. -The time between staff #1 turning to get staff assistance and staff #3 ' s entrance was under 5 seconds. -As staff #1 was notifying staff #2, staff #3 entered the hallway and directed the clients to stop their activity. -The clients immediately complied with staff #3 ' s directive and staff #2 is also viewed entering the hall from the med room at that time. -Staff #3 is seen attending to client #1 and walking her off camera. Interview on 6/14/22 client #1 stated: -She had been at facility for few months. -She had been in an altercation with peers several weeks earlier on an unknown date. -While on restriction on the 300 hall, she attempted to enter a dayroom and was stopped by peers. -She had been placed on restriction from the dayroom for behaviors exhibited earlier. -While sitting outside the dayroom on the floor,	V 110		

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V 110	Continued From page 3	V 110		

she tried forcing her way in to the dayroom by sticking her arm into the door.
-Several peers tried pushing her out of the dayroom and attempted to force the door closed.
-Two other peers tried grabbing her feet and began pulling her in an attempt at stopping her from entering the room.
-She felt staff should have intervened and did not try stopping her peers.
-She was seen by a nurse for pain in her arm right away and evaluated over the next several days.
-X-rays were taken of her arm and there were no injuries.

Interview on 6/14/22 Staff #2 stated:
-She had been at the facility for over a year.
-She had been working on the shift where client #1 had an altercation with peers outside the day room.
-She had been working in the med-room at the time of the incident on the 300 hall.
-She heard commotion in the hall and by the time she got into the hall her co-workers had already addressed the issue.
-Staff #1 had been in the hall observing client #1 at the time of the incident.
-She did not view what occurred.

Interview on 6/14/22 staff #3 stated:
-She had been with facility for approximately 2 years.
-She had been working on the shift where client #1 had an altercation with peers outside the day room.
-She was at the nurse station and could see videos of the hallways.
-From the live video, she witnessed client #1 ' s attempts to enter the dayroom from a seated position and client #1 ' s peers attempting to push

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V 110	Continued From page 4 her out. -She then witnessed client #1 ' s peers coming out and attempt to grab at client #1 ' s legs in an attempt to pull her from the day room. -She ran into the 300 hall and intervened to stop the situation from escalating. -Client #1 ' s peers immediately released client #1 and she then escorted client #1 to be evaluated by a nurse. -She was only a couple of seconds away from the hall and was able to intervene quickly. -She felt the need to intervene due to staff not taking action quickly enough. The staff present did not try to stop the girls. *Staff #1 was unable to be reached for interview.	V 110		