Division of Health Service Regulation

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 _____ DHSR - Mental Health	09/08/2023

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

SEP 25 2023
Lic. & Cert. Section

(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 September 8, 2023. Four complaints were substantiated (intakes #NC00205889, #NC00205897, #NC00205989, and #NC00206684) and 2 complaints were unsubstantiated (intakes #NC00205673 and #NC00205890). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents. This facility is licensed for 72 and currently has a census of 42. The survey sample consisted of audits of 7 current clients and 1 former clients.	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 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.	V 105	The facility's CPI Instructors prepared a list of direct care employees who were lacking a CPI refresher course within the past 6 months. The CPI Instructors will provide these employees this training and document their demonstrated competency per the standard, to include: •Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger emergency safety situations. •The use of nonphysical intervention skills, such as de-escalation, medication conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations. •The safe use of restraint and seclusion, including the ability to recognize and respond to signs of physical distress in restrained or secluded patients.	11/7/23

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

CEO — 9/21/23

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V 105	Continued From page 1 (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 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	• Date the training was provided and competency demonstrated. • Name of the instructor certifying the training. The Director of Human Resources will maintain a tickler file that documents the due dates for all direct care staff for their 6-month CPI refresher and will work with the employees' manager and the CPI instructors to schedule these employees for their semi-annual refreshers. Employees who exceed 6 months without completing their CPI refresher will be removed from the active schedule by the Director of Human Resources until the refresher has been completed. The Director of Human Resources will monitor the CPI training to ensure that no employees are deficient in their semi-annual refresher training. The Director of Human Resources will monitor the status of this training monthly.	

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V 105	Continued From page 2	V 105		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to develop and implement written policies for adoption of standards that assure operational and programmatic performance meeting applicable standards of practice for 1.) the training in non-physical interventions and the use of physical restraints semi-annually as required by CFR §483.376(f) for 3 of 5 audited staff (#1, #2 and #3).

Review on 9/6/23 of CFR §483.376 (f) revealed: "Staff must demonstrate their competencies as specified in paragraph (a) of this section on a semiannual basis...(a) the facility must require staff to have ongoing education, training and a demonstrated knowledge of: 1)Techniques to identify staff and resident behaviors, events and environmental factors that may trigger emergency safety situation; 2) The use of nonphysical intervention skills, such as de-escalation, mediation, conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations and (3) the safe use of restraint and the safe use of seclusion, including the ability to respond to signs of physical distress in residents who are restrained or in seclusion."

Review on 9/6/23 of staff #1's personnel record revealed:

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V 105	Continued From page 3 - Title of Mental Health Technician (MHT), hire date of 11/07/11 - Non-violent Crisis Intervention Training (CPI) was last completed on 9/04/22. Review on 9/6/23 of staff #2's personnel record revealed: - Title of MHT, hire date of 10/11/21 - CPI was last completed on 10/18/21 Review on 9/6/23 of staff #3's personnel record revealed: - Title of MHT, hire date of 11/21/22. - CPI training was last completed on 11/25/22. Interview on 9/8/23 the Director of Quality and Risk Management stated: - He understood the requirement for facility staff to have training in non-physical interventions and the use of physical restraints every six months. - He would ensure staff training was completed as required.	V 105		
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	V 114	The Director of Environment of Care will be responsible for ensure that both fire and disaster drills are held at least quarterly and repeated on each shift. This has been incorporated into the job description as a requirement for the new Director of Environment of Care. Indicate what measures will be put in place to prevent the problem from occurring again. The Director of Environment of Care will maintain a calendar of planned fire and disaster drills which will be provided to the CEO and Director of Quality, Compliance, & Risk Management on a monthly basis to ensure that all planned	9/30/23

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V 114	Continued From page 4 accessible for use. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to have fire and disaster drills held at least quarterly and repeated on each shift. The findings are: Review on 9/7/23 - 9/8/23 of facility records from 7/01/22 - 6/30/23 revealed: - 3rd quarter (July - September) 2022: No disaster drills documented for 1st, 2nd or 3rd shifts.. - 1st quarter (January - March) 2022: No disaster drill documented for 3rd shift. - 2nd quarter (April - June) 2023: No disaster drill documented for 3rd shift. Interview on 9/7/23 client #3 stated: - Fire and disaster drills were completed every few weeks. - A red code was announced over the intercom system for a fire, and she believed a gray code was announced for a tornado/hurricane. Interview on 9/7/23 client #4 stated: - Fire and disaster drills were completed every 2 months. - The fire and disaster drill response for the clients was to exit their room and meet in the hallway until they had been cleared to return to their rooms. Interview on 9/7/23 client #5 stated: - Fire and disaster drills were completed on a monthly basis. - A "code red" was announced over the intercom	V 114	drills are held as scheduled. Compliance will be reported monthly to Quality Council as a standing agenda item. The Director of Environment of Care is responsible for ensuring that both fire and disaster drills are held at least quarterly and repeated each shift. The Director of Quality, Compliance, & Risk Management will ensure each month at Quality Council that the fire and disaster drills have been completed for the month and document this in the meeting minutes. In the event the drills have not been held prior to Quality Council meeting each month, the Director of Quality, Compliance, & Risk Management will report this to the CEO, who will schedule the drills prior to the end of the quarter and personally ensure they are completed. The Director of Quality, Compliance, & Risk Management will ensure each month at Quality Council that the fire and disaster drills have been completed for the month and document this in the meeting minutes.	

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V 114	Continued From page 5 system for a fire, and a "code gray" was announced for a tornado/hurricane. - The fire and disaster drill response for the clients was to exit their room and meet in the hallway until they had been cleared to return to their rooms. Interview on 9/7/23 client #6 stated: - There had been 2 drills since his admission. - A "code red" was announced over the intercom system for a fire, and a different code (unknown) was announced for a tornado/hurricane. Interview on 9/8/23 Environment of Care Director stated: - He took over his role in the last year and was responsible for ensuring completion of fire and disaster drills. - He understood the requirement for drills to be completed quarterly and repeated on every shift and he would ensure drills were completed as required going forward.	V 114		
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	V 315	To improve recruitment and retention of direct care staff, the base salary for the position has been increased and the shift differentials have been increased to incentivize working evenings and nights, especially on weekends. 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 Committee meeting the number of staff scheduled for that day and the following day. 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	10/8/23

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V 315	Continued From page 6 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 9/7/23 of a sample of "Facility Daily Staffing Sheets" and census reports for 8/1/23 through 9/5/23 revealed: -200 Hall census ranged from 10 to 18 clients. The 3rd shift staffing ranged from 2 to 5 direct care staff on duty. -300 Hall census ranged from 10 to 13 clients. The 3rd shift staffing ranged from 2 to 4 direct care staff on duty. -400 Hall census raged from 9 to 12 clients. The 3rd shift staffing ranged from 2 to 4 direct care staff on duty. Interview on 9/7/23 client #1 stated: -She resided on the 300 hall. -There were generally 4 staff working on all shifts. -There had been some days where she had witnessed as few as one staff working on her hall over the last month. Interview on 9/7/23 client #2 stated: -She was admitted to the facility approximately 5 months earlier.	V 315	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 Program 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. To help fill vacant positions, the facility is also offering a recruitment bonus for any employee who refers an MHT who is hired. The facility is advertising the MHT position on multiple platforms, to include the facility website, Indeed, Glassdoor, LinkedIn, Handshake, and NC Works. The facility has also filmed a television commercial promoting employment at the facility to raise awareness and promote recruitment. The facility is offering a sign-on bonus for MHTs and is offering monthly employee engagement incentives for all employees. Additional scheduling options including different shift rotations and 12-hour shift options are being offered to attract candidates with varying work schedule needs. The facility has also joined the Brunswick County Chamber of Commerce to increase networking opportunities. To meet the 2:6 mandatory staffing ratio, one of the PRTF units has been closed and the census will be capped at 12 as needed on the other units. The Program Manager will monitor staffing ratio compliance and report to the CEO twice daily with an update the following day. The Program Manager will report to the CEO on staffing ratio compliance both at the daily morning leadership meeting and each afternoon	

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V 315	Continued From page 7 -She resided on the 300 hall. -There were generally 2 -3 staff working on all shifts. Interview on 9/7/23 client #4 stated: -She was admitted to the facility approximately 6 months earlier. -She resided on the 200 hall. -There were generally at least 4 staff working on all shifts. -There were as many as 18 girls on her hall at full capacity. -She had seen as few as 2 staff working the hall in the last month. Interview on 9/7/23 client #5 stated: -He resided on the 400 hall. -There were as many as 3 - 4 staff working on all shifts. -He had seen as few as 2 staff working over the last month. Interview on 9/7/23 client #6 stated: -He was admitted to the facility on 7/15/23. -He resided on the 400 hall. -There were usually 2 -3 staff on all shifts. -He had seen as many as 5 staff working his hall at one time. Interview on 9/7/23 client #7 stated: -She was admitted to the facility approximately 8 months earlier. -She resided on the 300 hall. -She had seen as many as 4 staff working the hall at one time. Interview on 9/8/23 the Director of Quality and Risk Management stated: -The facility had closed one hall to reduce the census number in order to meet staffing ratios.	V 315	Staffing meeting. A Scheduling Coordinator position has been created and filled in order to improve consistency of MHT scheduling and to ensure the schedule reflects sufficient staff coverage to maintain the correct ratios. The Human Resources Director and leadership team will hold bi-weekly new hire orientation classes instead of monthly classes to expedite the onboarding of prospective employees in order to increase hiring ahead of turnover. These bi-weekly new hire orientations will continue until staffing levels are adequate to maintain proper ratios at all times on all shifts. In addition to the base salary increases being offered to MHTs, the shift differentials have been increased to promote coverage of the historically more difficult to cover shifts on evenings and weekends. To help promote employee retention and minimize turnover and vacant positions, the New Employee Orientation schedule will be revised to promote employee engagement. Facility Managers will also meet with new employees at regular intervals to discuss engagement and satisfaction, training needs, etc. 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.	

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V 315	Continued From page 8 -The facility continued to work through staffing shortages with ongoing recruitment efforts to fill open positions. This deficiency has been cited 8 times since the original cite on 5/10/21 and must be corrected within 30 days.	V 315		