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	20040012	A. BUILDING: _____ B. WING _____	08/15/2023

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BRYNN MARR HOSPITAL	192 VILLAGE DRIVE JACKSONVILLE, NC 28546

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V 000	INITIAL COMMENTS A complaint survey was completed on August 15, 2023. One complaint was substantiated (intake #NC00205609) and three complaints were unsubstantiated (intake #NC00205397, #NC00206021 and #NC00206098). 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 18 and currently has a census of 16. The survey sample consisted of audits of 5 current clients.	V 000	Preparation and submission of this Plan of Correction does not constitute an admission of or agreement by the hospital with the alleged or conclusions set out in this Statement of Deficiencies. The Hospital submits this POC in accordance with the regulations and the Plan of Correction documents the actions taken by the Hospital to address the cited deficiencies.	
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) 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 (7) clinical skills.	V 109	Correction Action: The Chief Nursing Officer (CNO)/designee provided nursing staff with remedial training/education on proper handoff procedures using the SBAR tool, facility policies and standard procedures, to include Incident Report Policy, and the requirement to document and communicate serious incidents and allegations. Clarification regarding the responsibility to report all incidents/allegations to the supervisor and Risk Manager immediately was provided as well. Education was provided in small group settings and/or individually. Individual staff received corrective counseling that was included in their personnel records.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cynthia Wann

TITLE: CEO

(X6) DATE: 9/7/2023

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V 109	Continued From page 1 (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on interviews and record review, 1 of 4 Registered Nurses (RN #4) failed to demonstrate knowledge, skills and abilities required by the population served. The findings are: Review on 08/09/23 of client #15's record revealed: -15 year old female. -Admission date of 06/27/23. -Diagnoses of Disruptive Mood Dysregulation Disorder, Post-Traumatic Stress Disorder, Conduct Disorder, Cannabis Use Disorder and Nicotine Dependence. Review on 08/09/23 of Registered Nurse (RN) #4's record revealed: -Hire date of 12/05/22. -Job title: RN	V 109	Continued from page 1. Monitoring & Frequency: Nursing Supervisor/Manager reviews serious incidents and allegations with the Charge Nurse each shift and reports incidents daily to the CNO. CNO/designee reconciles incident reports with the Director of Risk Management and reports to CEO during Morning Flash Meeting or Supervisor Handoff. Nursing staff notifies Nursing Leadership, Doctor, and Therapist about all incidents/events as soon as possible. The CEO/designee audits compliance with RTC risk events and incident reports during Morning Flash Meeting or Supervisor Handoff. Any deficiency in reporting and handoff procedures is addressed immediately through corrective counseling. Incidents of non-compliance is addressed through individual corrective counseling and continued non-compliance results in additional corrective actions up to and including termination. The Director of Risk/designee reports aggregated data regarding compliance with incident reporting monthly in Quality Council and Medical Executive Committee and quarterly to the Governing Body. Responsible: CNO/Director of Risk	

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V 109	Continued From page 2 Review on 08/15/23 of a "Nursing Assessment/Reassessment" for client #15 signed by RN #4 and dated 07/29/23 at 5:22pm revealed: -No documentation of a "hit list" created by client #15 or communication to investigate the nature of the list. Review on 08/15/23 of a "Nursing Assessment/Reassessment" for client #15 signed by RN #4 and dated 07/30/23. -No time documented. -7a-7p circled. -"[Behavior] Blunted affect. Rude and disrespectful to peers and staff at times. Easily agitated when redirected. Pt (patient) defensive and angry when asked about 'hit list' yesterday, but was able to calm self upon explanation with staff. I (Intervention) Pt (patient) was redirected for the above behaviors Emotional support provided to pt by multiple staff members. Pt was placed on UR (Unit Restrictions) Sharps restrictions d/t (due to) safety related to reported 'hit list'..." Review on 08/15/23 of a facility "Progress Notes" for client #15 signed by RN #4 and dated 07/30/23 revealed: -"1100 (11:00am) late entry RN received report from MHT (Mental health Technician) on 07/29/23 @ (No time documented) that pt was sitting at a table W (with) multiple peers passing around a piece of paper. When MHT approached pt, the pt quickly grabbed piece of paper and proceeded to 'eat' it. MHT did report that she was able to read the heading which was named 'Hit list' she was unable to make out any specific names before pt grabbed paper." Review on 08/09/23 of the facility report dated	V 109		

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V 109	Continued From page 3 07/29/23 revealed: "-Date of incident: 07/29/23 Time: 1730 Shift: 2 Day: Sat (Saturday) -Lead MHT reported to RN that a 'hit list' was seen by another pt and once [Client #15] was approached she proceeded to put the paper in her mouth and eat it. RM (Risk Manager) notified by House Supervisor of the incident. Police responded to the facility, as contacted by a patient's guardian regarding this list...Patients have knowledge of this list but are unwilling to talk about it with staff. It is also believed that both male staff members and patients' names are on this list... Update: 07/31/23 RM informed that the list is a 'hit it and quit it' list and not a 'hit list' as previously reported, meaning sexual in nature. [Client #15] reported to staff that it is her business and not staff's. [Client #15] placed on sexual aggression precautions due to the nature of the list." Review on 08/09/23 of the Police Incident report dated 07/30/23 revealed: "-1. On July 30, 2023 at 0924 (9:24am) hours, I [Officer] responded to [Facility address] in reference to communicating threats. 2. Upon arrival I contacted the caller by phone and he identified himself as [Guardian]. He stated that his daughter, [Client #7] was admitted to the [Facility] about a year and a half ago. He stated that yesterday his daughter called him advising him that a group of females were gathered together in the hallway writing on a piece of paper. [Client #7] said that when she got close enough to see what the paper said she observed the sheet of paper showing a 'hit list' with multiple names listed below. She advised her father that [Client #15] then put the note in her mouth, eating it before staff could read it. [Client #7] then told her father that she was telling	V 109		

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V 109	Continued From page 4 the truth and she did not want the group of females finding out she told her father. 3. I (officer) also made contact with two females identified as [House Supervisor #2], and [RN #4]...[RN #4] stated she found out about the note yesterday (07/29/23) but forgot to report it to her supervisor. She advised me that he was not here when it happened, she was told this on shift change. 4. [House Supervisor #2] the supervisor of [Facility], advised me that she would be looking into the matter. None of this information could be confirmed due to the fact law enforcement could not get access to surveillance without 'risk management being there.'" On 08/10/23 Client #15's therapist advised against interview of client #15 due to current level of aggression and elopement seeking behaviors. Interview on 08/09/23 RN #4 stated: -She had worked as a RN at the facility for approximately 8 months. -She had been notified by staff #2 that former staff (FS) #1 had seen a "hit list" created by client #15. -Staff only had a brief look at the list before client #15 ate the paper. -She was notified at approximately "5 (pm) or so." -"I didn't (mention to supervisors), it was such a crazy afternoon that day." -She would normally report issues like that to the supervisor. -The police came the next day due to information a staff saw the list. -It was discovered the list was actually something sexual in nature. Interview on 08/09/23 the House Supervisor #2 stated:	V 109		

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V 109	Continued From page 5 -She was the House Supervisor and had worked at the facility for 15 years. -She recalled the police recently arrived to discuss a client "hit list." -The client ate the paper the list was on. -A parent had called the police due to a threat. -She was not aware of the list until the police arrived at the facility. -There had not been any threats or issues related to the list at the facility.	V 109		
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:	V 315	Corrective Action: Based on previous guidance provided by DHSR that the RN could be counted as part of the ratio in milieu for a brief period for short term coverage (i.e., staff breaks, bathroom breaks, etc.), but not as part of the daily 2 staff to 6 patients ratio, upon clarification it was determined that this was incorrect information. The Chief Nursing Officer reviewed and revised the Nursing Staffing Plan to exclude the RN assigned to the shift from the staffing ratio of 2 staff to every 6 patients to include break coverage. The CNO provided education to the Staffing Coordinator, Nursing Leadership, and nursing staff regarding the revised staffing guidelines during Nursing Staff Meetings. Nursing staff was also educated to immediately inform nursing supervisor or any staff issues. The CNO revised the Nursing Staff Meeting agenda to include a staff requirement for PRTF as a standing agenda item.	

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V 315	Continued From page 6 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 08/09/23 of client #13's record revealed: - 14 year old female. - Admission date of 06/14/23. - Diagnoses of Major Depressive Disorder-Recurrent, Attention Deficit Hyperactivity Disorder (ADHD), Disruptive Mood Dysregulation Disorder (DMDD), Bipolar Disorder and Post-Traumatic Stress Disorder (PTSD). Review on 08/10/23 of client #8's record revealed: - 13 year old female. - Admission date of 07/25/22. - Diagnoses of DMDD and PTSD. Review on 08/10/23 of client #12's record revealed; - 15 year old female. - Admission date of 06/16/23. - Diagnoses of DMDD, PTSD, Conduct Disorder, Bipolar Disorder, History of Sexual Assault and Suicide Attempts. Review on 08/09/23 of Licensed Practical Nurse (LPN) #1's personnel record revealed: - Date of hire: 10/11/21. - Title-LPN Review on 08/09/23 of Registered Nurse (RN) #2's personnel record revealed: - Date of hire: 03/09/20. - Title-RN Review on 08/15/23 of a "Nursing	V 315	Continued from page 6. Monitoring & Frequency: The CNO/designee reviews and confirms staffing ratio on the RTC schedule meets the required 2 staff per 6 patients each day prior to the beginning of each shift. The CEO/designee audits compliance with the RTC staffing ratio during morning flash meeting or Supervisor Handoff. Any deficiency in PRTF staffing is addressed immediately through staffing contingency plans. Incidents of non-compliance is addressed through individual corrective counseling and continued non-compliance results in additional corrective actions up to and including termination. The CNO/designee reports aggregated data regarding compliance with RTC staffing ratio of 2 staff to 6 patients monthly in Quality Council and Medical Executive Committee and quarterly to the Governing Body. Responsible: CNO	

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V 315	Continued From page 7 Assessment/Reassessment" for client #13 dated 07/23/23 and signed by RN #2 revealed: -"7/23/23 1400 (2:00pm) Pt (patient) (client #13) attempted to grab walkie talkie...off staff then took staffs glasses & broke them. Pt walked down the hall...& with encouragement pt handed pieces of glasses to staff - pt accepted support...pt agreed to meds (medications) . [Doctor] notified pt able to de-escalate [with] staff Doctor gave stat meds for 50mg (milligrams) Thorazine po [by mouth] & Benadryl 50mg po for mood changes - pt received stat meds at 1308 (1:08pm) - Periods of hyperactivity tossing box of tissue in air catching like a game-recovered by staff." Review on 08/09/23 of the facility incident report revealed: "-Date/Time/Day of Incident: Date: 07/26/23 Time: 1300 (1:00pm) Shift: 1 Day: Sunday -Nurse (LPN #1) was attempting to admin (administer) meds (medication) to patient (client #13) when patient struck cup of meds out of nurses hands, and when nurse went to retrieve meds, patient backed nurse into chair while pt (patient) was standing, attempted to obtain walkie talkie from nurse and got frustrated because it was somewhat concealed, put hands on nurses glasses and pushed them into bridge of nose before removing them from nurses face before breaking off both arms to glasses, bent the frames until visibly deformed, and tried to use one lens from glasses to scratch things into wall. Nurse left the unit and responding staff were able to retrieve all pieces of glasses." Review on 08/09/23 of a local police report for the LPN #1 revealed: - Dated 07/24/23. - "1. On 07/24/2023 at 21:28 hours (9:28pm) I, [Officer Name], responded to [LPN address] in	V 315		

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V 315	Continued From page 8 reference to a past occurring assault...3. [LPN #1] stated that she is an employee of Brynn Marr Hospital, and yesterday (07/23/23 at approximately 13:00 hours (1:00pm)) one of her patients assaulted her. [LPN #1] explained that she was attempting to give medicine to fourteen-year-old patient "[Client #13]", when the girl pushed up against [LPN #1]'s head in an attempt to retrieve [LPN #1]'s walkie-talkie. [LPN #1] explained that once [Client #13] realized she could not get her walkie-talkie, [Client #13] forcefully shoved [LPN #1]'s glasses against her face before grabbing them and taking them off. [LPN #1] explained that [Client #13] walked away with the glasses in hand, twisting and bending them until both legs broke off and both lenses popped out. 4. [LPN #1] stated that she went to [Local hospital] after the assault occurred due to company policy, and that the hospital advised that she had soft tissue damage along her face near eyes and bridge of her nose. 5. [LPN #1] stated that her glasses were from "[local eye shop]" and worth approximately $44.20. [LPN #1] was unable to provide any further personal information about [Client #13], which is why she is not listed as an offender in this report. [LPN #1] was informed that once she was able able to obtain more identifying information about [Client #13], to call [local] police department and refer to her OCA (Originating Agency Case number). While [LPN #1] had no visible injuries, photographs were taken and a [local police department] form 38 Photo I log was completed. [LPN #1] was provided an OCA card, as well as a Crime Victims' Right Act Victim information sheet, and told to call back once she had more information about [Client #13]. nothing further at this time." Review on 08/09/23 of a police "Case Supplemental Report" dated 07/25/23 revealed:	V 315		

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V 315	Continued From page 9 - "Offense: Simple Assault" - "On date of July 25 th, 2023 at approximately 1003 Hrs (hours) (10:03am) I contacted the victim, [LPN #1], by way of telephone and spoke with her regarding report. I informed her that the report had been reviewed and inquired as to if [Client #13] was there due to an IVC (Involuntary Commitment) to which [LPN #1] advised that she was a residential patient . I informed her that I would gather the additional information as I could from [Director of Risk Management and Performance Improvement]. The Risk Management and Human Resources staff member for Brynn Marr Mental Health Care, and attach it to the report; however, there were several complications to keep in mind when it came to prosecuting a case of this nature - referring to that of a mental health facility...." Review on 08/15/23 of the facility's surveillance video on 07/23/23 revealed: -Client #13 and two others clients were sitting at a table. -RN #2 and LPN #1 were the only staff in the room. -Client #13 got up from table. -Client #13 walked up to LPN #1 and backed her into a group of chairs. -Client #13 appeared to be grabbing for something on LPN #1. -Client #13 grabbed LPN #1's glasses from her face and walked out of the room. -The RN #2 and the LPN #1 followed client #13 out of the room and the other two clients were left in the room. -The entire video of the incident was approximately less than 2 minutes. Interview on 08/10/23 client #13 stated: - She recalled the incident on 07/23/23.	V 315		

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V 315	Continued From page 10 - She got upset and pulled the glasses off of LPN #1. - She did not know why she got angry. - LPN#1 did not do anything to make her angry. During interview on 08/10/23 the LPN #1 revealed: -She had worked at the facility for 2 years. -She was attempting to administer medication to client #13 due to client #13 being agitated. -Client #13 "slapped" the pills out of her hands. -She was attempting to get the pills and client #13 "backed" her into the line of chairs. -Client #13 started grabbing her walkie talkie that was tucked into her shirt. -Client #13 "shoved" her glasses in her face and she "ripped" her glasses off her face breaking the glasses. -RN #2 was present during the incident. -She knew one other client was present during the incident. -No other staff were present during the incident. -She suffered "soft tissue injury and a mild concussion." -She stayed out of work for 3 days. -She would be considered a Mental Health Technician (MHT) in "between medication times." Interview on 08/09/23 and 08/15/23 RN #2 stated: - She had worked at the facility for 3 years and 4 months. - She was a RN. - She recalled the incident on 07/23/23 between client #13 and the LPN #1. - She thought the clients were client #13, #8 and #12. - She and the LPN #1 were with the 3 clients approximately one hour. - She did not recall where the other clients were. - The clients feed off "negativity" at times.	V 315		

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V 315	Continued From page 11 - "I was spread thin." - There should have been another staff in the unit. - She was acting as a Mental Health Technician since she was outside the nurses station. - Client #13 went to the LPN #1 and grabbed her glasses. - Client #13 broke the LPN #1's glasses. - She called a code to request for assistance. - She did not see any specific injury on the LPN #1 except her eyes were red from crying. - She heard the LPN #1 had a "corneal abrasion." - It was "not usual for her to be acting" in the mental health technician staff role. During exit conference on 08/17/23 the Director of Risk Management revealed: -She was not aware of any injury for LPN #1 after the incident with client #13. -She had been told by previous "state" workers that the nurses could be used as part of the staff to client ratio. -From her understanding the nurses were not with clients all day. -The nurses were with the clients "at times" to make sure the ratio was met. -"If consistent communication had been given to them they would not have used the RN and LPN as part of the ratio." Review on 08/15/23 of the Plan of Protection dated 08/15/23 and completed by the Director of Performance Improvement on 08/15/23 revealed: "-What immediate action will the facility take to ensure the safety of the consumers in your care? -Nursing/Nurse is not included in the staffing ratio (2 to 6). -The facility will ensure that the RN is not included in the staffing ratio. -Describe your plans to make sure the above	V 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20040012	A. BUILDING: _____ B. WING _____	08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 315	Continued From page 12 happens. -Staffing will be reviewed through out the day by the scheduler and nursing leadership. -Staff will be educated to immediately inform nursing supervisor of any staff issues. -Staff requirements for PRTF will be a standing agenda item in the nursing staff meetings." The clients' ages ranged from 13 to 15 years old. Their diagnoses included Major Depressive Disorder-Recurrent, Attention Deficit Hyperactivity Disorder, Disruptive Mood Dysregulation Disorder, Bipolar Disorder and Post Traumatic Stress Disorder and Conduct Disorder. On 07/23/23 RN #2 and LPN #1 were in the lounge with three clients and no other staff. Client #13 became agitated with LPN #1 and began grabbing her walkie talkie and glasses resulting in the glasses being broken and the report of a facial injury per LPN #1. RN #2 and the LPN #1 were included in the staffing ratio and no other Mental Health Technicians were present during the time of the incident. The facility failed to ensure the required direct care staff to client ratio. This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 315		